Job Relations
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the MODERN HOSPITAL

VOLUME 62 JUNE 1944 NUMBER 6

BACK IN "CIVVIES"

for civilian Nurses and Orderlies

WECK METAL-HANDLED RAZOR

GOOD NEWS **– for hospital nurses and orderlies – sufficient metal has been released by the W.P.B. to permit Weck to make again its famous METAL-HANDLED preparation razors!**

Once more you can sterilize these razors and not have to worry about plastic handles – for they have been replaced by the old reliable – dependable – metal ones.

WECK "PREP" RAZORS are made in two sizes: for Orderlies, 5¾" long ⅞" wide, fitted with standard size Weck replaceable barber's edge blade, and reversible metal guard.

For Nurses – size 4¾" long – weight slightly over an ounce. Uses same size standard blade as Orderlies.

The leather cases (illustrated above) are scarce, though, and hard to get. If we have them when we get your order, we'll send them. If not, your razors will come attractively and serviceably packed in cellophane. So order promptly to have a chance at leather cases.

Orderlies' Size $1.50 each $18.00 dozen
Nurses' Size 1.00 " 12.00 "
Blades also available in cartons of 50@$3.34 a carton.

Immediate Shipment

Edward Weck & Co., Inc.

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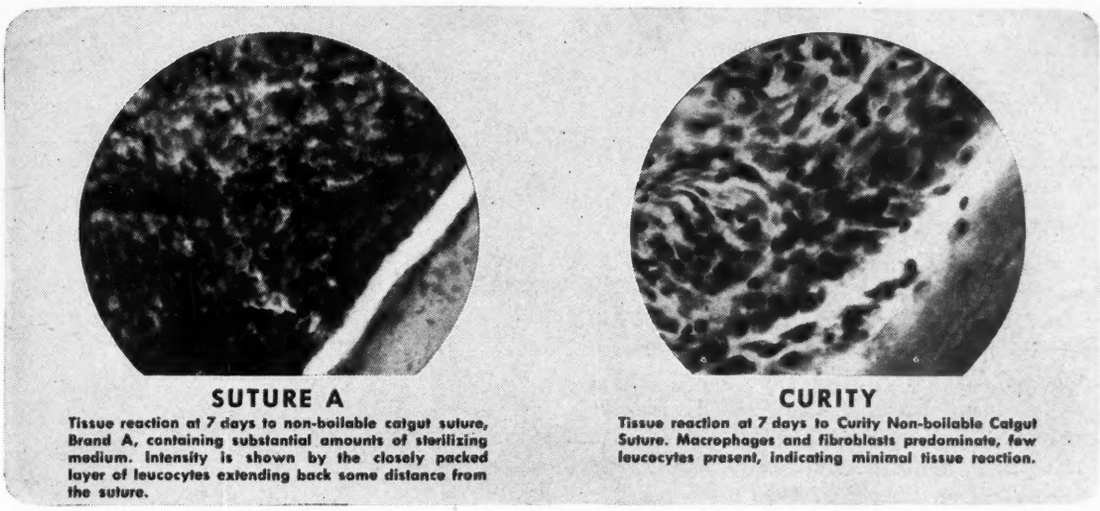
SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street Brooklyn, N.Y.

Report of RESEARCH in tissue irritation



SUTURE A

Tissue reaction at 7 days to non-boilable catgut suture, Brand A, containing substantial amounts of sterilizing medium. Intensity is shown by the closely packed layer of leucocytes extending back some distance from the suture.

CURITY

Tissue reaction at 7 days to Curity Non-boilable Catgut Suture. Macrophages and fibroblasts predominate, few leucocytes present, indicating minimal tissue reaction.

Investigations of various non-boilable catgut sutures demonstrated that residual sterilizing medium, long a result of the standard high-heat process used by suture makers in sterilizing non-boilable catgut, produces tissue irritation in approximate proportion to the amount of sterilizing medium present in the finished product.

Bauer & Black has perfected a refinement of the sterilizing process which reduces the residue of sterilizing medium in Curity Non-boilable Catgut Sutures to a minimum that is not significant in tissue irritation. The refined process also controls this minimal content and eliminates its variations.

★ ★ ★

Thus the Bauer & Black continuing research program again offers you a finer Curity Suture.

Curity Sutures for your SPECIAL needs

With doctors and hospitals, Curity Specialty Sutures and Emergency Tubes are more and more important as timesavers, and as effective tools in the interest of better surgery.

For hospital or home delivery, Curity OB and Circumcision Sutures with eyeless needles are ideal . . . and, to meet a wide range of situations, there are the Curity Emergency Tubes which give you a choice of six materials, in a satisfying variety of gauges, with the standard half-curved cutting needle.

Plastic work and the more critical repairs call for Curity Single Filament Zytor with an eyeless needle. Also available are Dermal Sutures with three types of eyed needles for general skin suturing.

Ask your dealer—or the Bauer & Black representative—for Curity Specialty Sutures.

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SUTURES

SUTURE RESEARCH . . . TO ESTABLISH A FINE BALANCE OF NECESSARY CHARACTERISTICS

CONTENTS

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THE ROVING REPORTER

Meet the "Draw Sheet"

Ever since it first came out some months ago, the Roving Reporter has had in mind to say something about the *Draw Sheet,* a bulletin issued each month expressly for the personnel of Lake Forest Hospital, Lake Forest, Ill. Its chief claim to distinction is the manner in which it is written, bright and lively and covering happenings that make good reading. The description of a Russian meat cake recipe sounds interesting even, which is an accomplishment.

Genevieve R. Jeffrey, superintendent, ascribes much of the help and inspiration she has received to the chairman of the hospital's motor corps. Is there no end to what these volunteers can accomplish? Last fall when Mrs. Jeffrey suggested that she would like to try her hand at publishing, this woman agreed to assist, which she has been doing conscientiously and most effectively ever since.

They obtained the clever title by soliciting suggestions in the form of a contest. The winner turned out to be none other than Mrs. Jeffrey herself. So she offered her prize of $5 in war stamps to the employe who could describe in the most interesting style the work of his or her department. It went to someone in the kitchen. All of which promotes better personnel relations, which is precisely why the *Draw Sheet* was conceived.

Cavalry Patrol

The only hospital your Roving Reporter ever visited that has a cavalry detachment on duty is the famous Halloran General Hospital on Staten Island, New York. The mounties patrol the 383 acres which make up the hospital's grounds. We started to tell you why but the censor said, No. Ask us after the war and we'll explain it all. Col. Ralph G. DeVoe is the commanding officer.

It's Home to Anna

Anna Cassinelli was singled out for a special award recently when the Hospital for Special Surgery, New York City, presented service awards to 120 employes at an impressive ceremony. The presentations were made at a tea in the hospital's lecture hall, the occasion being the twentieth anniversary of the opening of the physical therapy department. Employes who have served the hospital for five years or more received the awards.

The hospital is Anna Cassinelli's only home for she was brought there 45 years ago, a child suffering from an obscure disease. She has no recollection of her mother who had died when she was an infant.

When Anna was 12 the hospital gave her a job in the sewing room where she has earned her living ever since making orthopedic corsets and surgical supports for other handicapped persons. Anna is only 3 feet tall and she has a special sewing machine made in proper scale. She is a devout Catholic and every Sunday finds her on her crutches at a near-by church.

The Hospital for Special Surgery (formerly Ruptured and Crippled) was one of the first institutions in the United States to have a physical therapy department. It started the first course for technicians. In 1940 the Army asked the hospital to accelerate this course for training its technicians.

Something Worth Celebrating

Lucy Van Horn, R.N., was 70 on the same day that Hitler was 55. She did not wish Hitler's natal day to be observed so her nurse friends at Roseland Community Hospital, Chicago, postponed her birthday celebration until a day or two later.

Miss Van Horn retired from nursing in 1940, thinking after forty years of active nursing she deserved a rest. She rested for two years and then the word reached her in the quiet village where she had gone to live that the nursing shortage in Chicago was getting acute. So Miss Van Horn packed up her uniforms and reported to Roseland Community for a job.

"We gladly put her in charge of supplies on the maternity floor," Mrs. Ila Markle, director of nurses, declared. "She's doing a wonderful job."

Her colleagues think so, too, so that is why they "threw" a real party when she reached her three score and ten.

Hartford Blitzed by Stork

The largest nongovernmental hospital in the United States has broken or equaled some other national records. Claiming the largest percentage of increase in patients of any hospital in the United States—a figure substantiated by the A.M.A.'s annual census—Hartford Hospital in Hartford, Conn., has had a 134 per cent increase in the number of births in the last four years. Here's how Dr. Wilmar M. Allen, the director, puts it:

"Never ending squadrons of storks have bombed us with 17½ tons of babies, of which 42 were block-busters weighing more than 10 pounds. There were some incendiaries with the spark of life weighing as little as 1 pound 13

PENICILLIN

★ FROM THE BEGINNING, Eli Lilly and Company has been active in the development of Penicillin, and for several months has made it available to the armed forces on government allocation and to the Office of Scientific Research and Development.

The material has been so scarce that very little has been available for civilian use, and then only on special assignment. Even in army and navy hospitals it often was restricted to patients unresponsive to sulfa-drug treatment.

Penicillin is now more generally available, and research to achieve the ultimate in chemotherapeutic perfection continues as a major project in the Lilly laboratories. Eli Lilly and Company, Indianapolis 6, Indiana, U.S.A.

Lilly BUY WAR BONDS FOR VICTORY

ounces. There was no damage and casualties were extraordinarily light. According to official communiqués, no storks were shot down so we may expect continued assaults. Forty-nine hundred and one mothers gave birth to 4952 babies, of which 74 were still-born."

The maternity mortality rate in this hospital was 0.88 per thousand. The still-birth rate was 1.36 per cent and the mortality rate in the newly born, 1.53 per cent, all outstanding achievements.

The siege of Hartford conducted by the stork squadrons is bound to ease off, according to statisticians of the Metroplitan Life Insurance Company. In September 1943 births began to drop nationally and by last December they had fallen 22 per cent below the December peak of 1942. The reason: more fathers have gone overseas. Since the state of Connecticut is an arsenal, draft deferments may have a delaying effect on the drop in birth rate.

Patients as Attendants

"Two years ago it would have seemed almost too absurd to think about," says Harry Kromer, R.N., chief occupationaal therapist, "but today at Norwich State Hospital, Norwich, Conn., we are actually using patients as hospital attendants."

Selected patients are referred to the medical staff for approval and are then given a short period of instruction, uniforms, keys, special living quarters and a ticket entitling them to eat in a special dining room.

Starting with a few patients at first, 25 were soon serving as attendants and were doing good work. In fact, they were doing such good work that several of them were able to be discharged to their homes and others have found jobs outside the hospital. Two discharged patients are now on the hospital's pay roll.

"The incredible part of the whole project," Mr. Kromer reports, "is that during this period there have been only three demotions for infractions of the rules."

The personnel director at Norwich is running a full page display advertisement on the back page of the hospital's house organ, the *Stylus,* asking relatives and friends of patients to search out and refer to the hospital anyone who is willing to work full time or part time at the hospital.

It All Helps the Patient

So much is done in a recreational way for mental disease patients that it sometimes seems hardly worth while to keep up the struggle for sanity. The patients at certain state hospitals are kept busy at pleasant tasks and entertained so whole-heartedly that their lot seems a happy one.

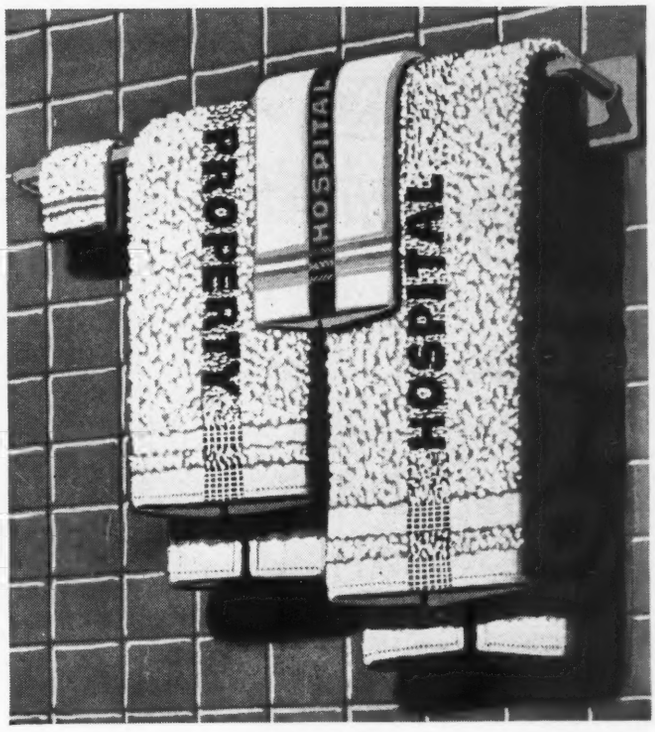
For instance, at Norwich State Hospital roller skating classes are proving popular. For the slow and retarded groups it is stimulating and for the overactive it helps control the output of energy. It also acts as a sedative. It's taboo, of course, for older patients as fractures from falls must be avoided.

The drum corps is another new activity at Norwich. The discharge rate from the corps is so high that the occupational and recreational therapy department has an entirely new drum corps every few months. There are two groups, beginners and advanced.

Cabaret life without the government tax is enjoyed periodically as the regular dances give way on special occasions to floor shows, the talent being partly from patients and partly from outside friends of the hospital. Masquerade balls are popular, too.

Among the many shops at Norwich is a new upholstering shop. It does all the upholstery work for the hospital, completes most of the final refinishing on furniture, makes new and repairs old window shades and remakes mattresses.

Each ward has its own flower garden project for which the patients assume the entire responsibility.



TOWELS and Plenty of Them

Towels head the "must list" of items in every hospital in hot weather.

Fillman today has a complete stock of towels in a variety of sizes to serve every distinct hospital need. These towels are produced with particular regard to absorbent properties and have a smooth, soft finish which remains soft after laundering.

TURKISH TOWELS—All white or with "Hospital Property" or "Nurses' Home" woven in colored stripe—steam, face or bath sizes.

TURKISH WASH CLOTHS—(white or colored).

HUCK TOWELS—All white or with "Hospital Property" or "Nurses' Home" woven in colored stripes—face and hand sizes.

HUCK TOWELING in the piece or by the yard.

Fillman quality in textile specialties has been recognized by hospitals for over 50 years. Our towels are built to suit your purposes, and like all Fillman fabrics are created to withstand hard usage and the many necessary trips to the hospital laundry.

We suggest that you cover your requirements promptly, not only for towels but all textile necessities. There is a shortage today on some items and the market will be more curtailed later. It will be wise to anticipate your needs.

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READER OPINION

Designing Hospital Furniture

Sirs:

A student nurse here is interested in taking a course in designing hospital furniture and equipment. Where would she be able to take such a course? Where can she obtain information on the subject?

Sister Mary Magdalen, R.S.M.
Director of Nurses
Mt. Carmel Mercy Hospital
Detroit

Apparently no university or art institute is offering such a course. Several manufacturers report that there is a real shortage of designers in the hospital field. One says that "as a result, a lot of hospital equipment, while it is truly engineered, is not properly styled."

Another reports that this student nurse would need unusual qualifications. "Not only would she have to be adept in drafting and have a good knowledge of hospital application of equipment, but she would most certainly need a background experience of building that furniture. There is the wood angle, the metal angle and now the coming plastics angle. Certainly, a course in interior decorating would be most helpful. There is really a lot to learn in the construction of wood furniture alone and it might save her time and expense if she started with an interior decorating course and made her plans from there."

Another manufacturer says that "the designs of our line are a composite of ideas obtained from various hospital administrators from a practical point of view."

A further suggestion is that the student gather various catalogs and study them to see what basic ideas she can develop further.—Ed.

Where the Angels Week-Ended

Sirs:

While in this country I am taking as much time as possible to learn how the English system of panels and public health security works as I have an idea that this is going to be one of the biggest jobs that will have to be done when this war is over, and whether we are back in the States or whether we are attached to some unit that is working in Europe or some other place the result will bear directly on our own status.

Being in England and being surrounded with the beauties of the countryside I am most happy. Our location is on an old estate and that in itself says that we are well supplied with pleasant surroundings, plenty of trees and shrubbery which now are almost in full leaf. I hesitate to think of the pleasure that this summer will bring with the various flowers standing out in full and presenting such a pretty picture in which to do our work.

Your abstract, "A Week End With the Angels," published in the April issue, happens to be about the hospital with which I was formerly connected and made me smile, realizing that some of the same practices are thrust upon Army patients. I began asking questions, so far without coming up with any good and sufficient answers. Perhaps when I find the answer the present conflict will be over and I shall be able to apply that answer to the civilian hospital again.

Lt. Col. Albert G. Engelbach
7th General Hospital
APO 138
c/o Postmaster
New York, N. Y.

Thanks From W.P.B.

Sirs:

In behalf of the War Production Board it is a sincere pleasure to thank you and your staff for the whole-hearted cooperation portrayed in the excellent space allotted to the government's waste paper program.

Unselfish efforts, such as you have expressed, help in no small way to expedite the big job we all have to do.

W. M. Scanlan
Chief
Chicago District Salvage
War Production Board

"In Nead of Dockering"

Sirs:

A short time ago we received the enclosed postal card which I thought might amuse you. The "Miss Bartin" to whom the card is addressed, is our assistant medical social service worker and she spells her name "Barton."

The card comes from an elderly man who we judge is over 60 years of age; he has been a patient in our medical clinic and at the time was awaiting admission to the hospital.

The card read as follows:

"Miss Bartin
Mane Bilding
Vasser Hospital
Poughkeepsie, N. Y.

"Friend

this is Mr. Thompson Have you forgot me i nead tending to right away in nead of dockering please atend to it
W Thompson"

J. J. Weber
Administrator
Vassar Brothers Hospital
Poughkeepsie, N. Y.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Personnel Health

Question: Who is responsible for the health program of the personnel not included in the nursing department?—A.B., Mich.

ANSWER: The responsibility for the organization of a health program for employes is that of the administrator of the hospital. Because of the absence of a sufficiently organized house staff, direct responsibility would have to be delegated to a medical staff member or members, each member being assigned a specific group. In some hospitals a small health fee is deducted regularly from salaries, which gives the staff man some remuneration and makes possible a clearer definition of the services to be received by each employe.—ARDEN E. HARDGROVE.

Rubberized Pillow Covers

Question: Is it desirable to cover all pillows with a rubberized fabric?—R.B.N., Ore.

ANSWER: It is inadvisable to cover all pillows with a rubberized fabric. In warm weather they become moist and uncomfortable. I would suggest instead having on hand a number of removable rubberized pillow cases. They are easy to clean and may be used as indicated by the condition of the patient.—ELIZABETH ODELL, R.N.

Treatment for Impetigo

Question: What routine prophylactic measure is best to follow for impetigo?—F.C., Wyo.

ANSWER: Babies are sometimes born with lesions of impetigo on their bodies. This we have repeatedly observed in our own clinic. This must be an infection transmitted through the placenta and we do not know how to avoid it. The father should be shown the baby who is born with such lesions immediately. If demonstration is delayed until the next day he will refuse to believe that the baby did not catch something in the hospital. Installation of ultraviolet ray helps in all air-borne infections.

When one case of impetigo occurs further cases probably are contact infection. An impetigo baby should be at once placed in an isolation nursery. To prevent carrying infection from one infant to another, the following routine has been found useful.

Long scrub (with brush): Upon entering nursery; after handling an "isolated" infant, and after handling infectious material.

Technic: Nurses (short-sleeved gown); physicians (long-sleeved gown).

1. Wet hands and arms to elbow (nurses); wet hands to above wrists (physicians).
2. Lather and scrub with liquid soap and brush, especially between fingers, around nails and palms, each hand for at least two minutes.
3. Rinse in running water (don't turn off faucet with hands).
4. Dry on clean individual (preferably sterile) towel.
5. Allow about one teaspoonful of Price's solution to flow from dispenser into palm of hand; distribute over both; rub briskly until dry by evaporation.

One minute wash (no brush): Between well infants; before touching an infant, crib, bottle or supplies that will come in contact with an infant, and after touching mask, handkerchief, door knob, window shade.

Technic: Same as above, except soak and lather hands with liquid soap for one minute (no brush).

The proper use of small squares of autoclaved newspaper to handle lids of sterile containers, scales, forceps, telephone and door knobs will prevent contamination and eliminate many one minute scrubs.—W. C. DANFORTH, M.D.

When Does a Laundry Pay?

Question: Is it advisable for a 50 bed hospital to operate its own laundry, or should such service be purchased?—F.O., Mich.

ANSWER: A hospital of 50 beds or more would find it most advantageous to operate its own laundry. We speak from experience, having established a laundry in our institution in 1940. At that time, sufficient equipment was purchased to provide for all of the hospital wash without having any of this work done outside. Since the new department was established, the patient day cost for laundry has decreased from 58 cents per patient day in 1938 to 23 cents per patient day in 1941, a decrease of 120 per cent.

For the year 1942, with a higher number of admissions, the total cost of operating the laundry was $5,304.95, which represents a cost of 25 cents per patient day. It is also interesting to note that since 1938, with the exception of 1941, the cost of our laundry has gradually decreased in spite of the fact that during these five years, the patient census has steadily increased.

During 1943, we spent $8,410.41 to operate the department and cared for 456,500 pieces of linen at an average cost of 1.8 cents per piece. It is estimated that the average hospital uses from 12 to 17 pounds of linen per patient day. We estimate that our pieces average about half a pound each. The commercial cost here in Detroit is 4 cents per piece, so that in our case we are saving more than 50 per cent in operating our own plant.

Furthermore, during this critical period, there is a pick-up and delivery delay of from ten to fourteen days, which naturally means that the institution must have a much larger linen supply in order to meet daily demands. Even in normal times a laundry within the hospital is of particular advantage because less linen is necessary.

Two other small institutions in Detroit of not more than 60 beds operate their own laundries to advantage and claim much for it as regards savings and efficiency.—WILLIS J. GRAY.

Nurse Should Sign Charts

Question: How can clerical work of nurses be reduced? Is it advisable to have a lay employe do the charting so as to relieve the nurses?—D.J.R., Calif.

ANSWER: A number of schools of nursing today are working on methods of simplifying and reducing clerical work by eliminating unnecessary material and using approved abbreviations. Lay employes and volunteers are now copying temperature, pulse and respiration readings on the graphic sheet in some hospitals. A great many hospitals, especially those that have schools of nursing, believe that the nurse who carries out a procedure should record and initial it.—ELIZABETH ODELL, R.N.

Transporting Infants

Question: What method of taking babies to breast in the maternity department is most satisfactory during the present crisis because of the shortage of nurses?—F.C., Wyo.

ANSWER: We have found no satisfactory method except the individual transportation of babies to their mothers, one at a time, by a nurse. A cart accommodating a number of babies has been tried but given up because of (a) too much contact, (b) greater risk of giving a baby to the wrong woman.—W. C. DANFORTH, M.D.

How Does Fine Quality Become Inherent?

WHETHER you buy medical equipment for private practice or for a hospital, always it is with the hope that time and experience will prove that you correctly judged its value.

Your investigation of variously offered products is, of course, primarily in view of determining which offers most toward helping to render a better service to patients; price alone is not your determining factor, as with ordinary commodities.

If you haven't had experience with G-E x-ray or electromedical equipment, you'll not take for granted that it is of the fine quality you are looking for. But to countless thousands of other physicians, hospitals, and clinics, the world over, equipment bearing the GE *trademark* is accepted without question, because they have learned from experience that in all G-E equipment this desired fine quality is inherent.

This reputation for inherent fine quality has been earned the hard way—by strict adherance to definitely established policies and ideals throughout a half-century of service to the profession. And it perhaps best explains why a G-E apparatus, wherever it may be used—in physicians' offices, or in civilian or military hospitals, in any and all climes—always can be relied upon to give the eminently satisfactory service that characterizes all G-E products.

Though your plans for buying an x-ray or electromedical apparatus may yet be rather indefinite, may we suggest that in the meantime you obtain further information through our local representative, whose branch office address we will be glad to send you. Address Dept. J46.

Today's Best Buy *U. S. War Bonds*

GENERAL ELECTRIC X-RAY CORPORATION

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LOOKING FORWARD

Volunteer Activities

THE importance of volunteer organizations in hospitals, many of them in charge of paid directors, prompts the pertinent question, "What about women's auxiliaries in the postwar period? Have they served their purpose and will they continue to function as such?"

It is difficult to conceive of any voluntary hospital program without the loyal support of these staunch friends. Their contribution in time, money and effort is a matter of record. When hospitals were faced with dire emergencies they, with thousands of others, stepped into the breach and saved the situation. Not women alone but men volunteered for menial or exacting tasks which they continue to fulfill with distinction.

The spirit of the women's auxiliary will survive and must be sustained. Yet by reason of its broader functions and the effective teamwork of men and women in rallying to the support of hospitals a change in nomenclature seems logical. The term "volunteer division" would more accurately define active participation in hospital affairs; the auxiliary would then become a society of sustaining members who if less active would be nonetheless interested in hospital affairs.

So plainly discernible is this trend that The MODERN HOSPITAL in deference to the vast army of men and women hospital volunteers this month changes the title of its department hitherto known as "Women's Service Groups," to the more embracive "Volunteer Activities."

Our Rehabilitation Program

IF FOR no other reason than that it revealed how much we have to learn on the subject, the recent conference on convalescence and rehabilitation held in New York under the auspices of the New York Academy of Medicine is a significant step in the direction of postwar rehabilitation. Speaking principally from the standpoint of wounded and sick veterans of the present war, the observations of the 40 participants hold significant implication upon civilian convalescence.

According to the interpretation of Surgeon General Ross T. McIntyre, rehabilitation constitutes all activity and service that may be required to supplement ordinary and therapeutic procedures in order to achieve the maximum adjustment of the patient. Whether such procedures apply to war veterans or to civilians makes little difference; the general principles are the same.

It becomes apparent that the inadequacies of convalescent care in the past may be attributed to failure to apply what is already known rather than to lack of knowledge on the subject. It is to be hoped that, faced with a great need, not only will we review existing knowledge but medical, public health and hospital authorities with all social agencies will devote renewed study to the problem and from the work now being carried on in rehabilitation centers will develop a sound program for the future.

"We need to take convalescent care out of the legendary zone of medicine," to quote one authority. To which we might add: "We need to take convalescent care out of the legendary zone of hospitalization."

More will be heard of the subject from this point on. The New York Academy of Medicine has set the pace.

Advisers Ill-Advised

HOSPITALS that have been omitted from the list of "depot hospitals" authorized to store and distribute penicillin are being regarded by the public as third-rate institutions. Many of them are not. They resent, and justly, the widespread publicity that has been given to a list of 1000 hospitals compiled by the "advisory panel" to the Office of Civilian Penicillin Distribution.

Just who constituted this advisory panel? Their names have not been published but they are said to represent the W.P.B., the U.S.P.H.S. and the American Medical Association. All of these are fine organizations but when one looks at the results of their labors in this particular and notes the hospitals that have been included and those that have been excluded, it becomes apparent that a serious mistake has been made.

That mistake, and it should not be repeated, is to omit from such a panel all representatives of hospitals. Surely, the American Hospital Association is now sufficiently mature and public spirited so that its representatives could participate in the compilation of such a list. Government officials should realize that, while doctors and hospitals work closely together, the Amer-

ican Medical Association does not any more represent hospitals than the American Hospital Association represents physicians. Whether the choice was made in Washington or Chicago, hospital participation could have been obtained for a five cent phone call.

The Unexpected Guest

WHILE every administrator doubtless wishes to be courteous at all times to all visitors to the hospital, it is becoming increasingly difficult during these days to devote time to the professional visitor who appears without any forewarning whatever. Frequently, he comes from out of town, planning to spend a day or at least several hours inspecting one or more departments. Often he wants detailed information on many subjects.

Administrators are always glad to share their experiences with their co-workers. Through such cooperation much of the progress in hospital administration is made. But this courtesy should call forth equal courtesy from the guest. Today, one does not go to the tailor, beauty parlor, dentist or physician without an appointment and expect immediate attention.

If, perchance, the unannounced visitor arrives on the day of the annual meeting, the budget hearing or some equally absorbing occupation, the administrator cannot appear leisurely and helpful. A letter or phone call in advance would save embarrassment on both sides and make the visit more productive.

Educating the Administrator

THE great enthusiasm manifested at the first institute for fellows of the American College of Hospital Administrators held late in April at the University of Minnesota is an auspicious beginning to the college's expanded program of service. Those who attended the institute corroborated the opinion of the A.C.H.A. officers that there is a place for such a course designed to deal only with broad social trends.

There has, of course, been some muttering by the members and nominees of the college who were not eligible for this course. Officials of the college would not deny that many of them are entirely capable of participating in such an institute. But since the college has been criticized a bit for not being more selective in its choice of students for institutes, it should not now be criticized when it does become selective. After all, if the college does not take its own graduations in membership seriously, who will? There should be some prerogatives of fellowship.

Furthermore, this institute for fellows is but one part of a well-rounded educational program that the college is developing. When the full program is in operation there will be ample openings for everyone, whether beginner or advanced, and whether he can travel or must study at home on the job.

A committee of the college has been at work for some months compiling information concerning the extension courses that are now available from recognized universities. It will publish a list of those that are of value to hospital administrators. This list will be made widely available to the hospital field. Later it is hoped that the committee can recommend a coordinated educational program that can be pursued through extension work.

Many administrators who are making careful plans for their own educational advancement will find much of interest and value in the existing courses. Work can be taken in such fields as accounting and business organization, preventive medicine and public health, sociology, economics, psychology, personnel administration, government, law, English, finance, insurance and other broad fields or specific subjects that might be of value to particular administrators.

The stimulating experience of the Armed Forces Institute in taking education to the far-flung battlefronts probably points the way to great postwar improvements and expansion of education by mail. The A.C.H.A. is preparing to play a prominent part in this movement.

Scholarships for Instructors

THERE are known to be about 3200 unfilled teaching, supervisory and head nurse positions in schools of nursing and in hospitals, according to information just received from Elmira B. Wickenden, executive secretary of the National Nursing Council for War Service. Many other positions, she says, are filled by persons lacking necessary experience and training.

The opportunity to fill these positions more satisfactorily lies with nurses and hospital administrators. Hospital administrators should grant promising nurses leave-of-absence to attend summer courses and the institutions might well reimburse these nurses for the cost of the course after they have returned and served in the hospital for a reasonable period.

While they are taking such courses, properly selected nurses will be classified as essential by the Procurement and Assignment Service for Nurses.

More than 150 courses, institutes and workshops will be offered this summer by colleges and universities in all parts of the United States. The April issue of *Professional Nursing,* published by the Nursing Information Bureau, 1790 Broadway, New York City 19, lists many of these courses, which will deal with administration of schools of nursing, administration of public health nursing, health education, industrial nursing, personnel work or guidance, principles and practice of public health nursing, psychiatric nursing, teaching of science and nursing arts, tuberculosis nursing, venereal disease nursing, ward management and ward teaching and supervision.

A few of the courses have already started but many others begin in June. Prompt action is, therefore, essential.

HEADLINE NEWS

Commonwealth Fund Ready to Grant $300,000 per Year for Coordination

In line with the increasing emphasis on the regional coordination of hospitals, the Commonwealth Fund of New York City, through its division of rural hospitals, announced on May 19 plans to undertake a large experiment in regional organization of hospital service in a suitable area to be selected.

The fund is prepared to consider contributions up to $300,000 a year for a minimum of five years and decreased amounts thereafter.

The program may embrace administrative, medical and technical consultation, educational activities and building operations within the region chosen. Correspondence is invited with institutions, organizations and agencies in a position to cooperate in the experiment.

The fund has been interested in the rural hospital field for the last eighteen years and has given funds and advice in the development of 15 rural hospitals.

"This experience," the fund states, "has pointed to the need of some form of organization whereby the services of consultants naturally concentrated in the cities and medical centers will be made available throughout the area." The fund believes this may be accomplished by a voluntary association or council representing the hospitals of the region, through which coperative relationships between hospitals in the regional center and the surrounding area would be set up.

The presence of a medical school would be advantageous, the fund states, and voluntary insurance plans may be included if desired.

Opportunities for postgraduate study for administrative, professional and other personnel of participating institutions should be provided. Even new construction, additions and improvements to present buildings can be included.

Numerous authorities have predicted that regional coordination of hospital work will be a major recommendation of the National Commission on Hospital Service which is soon to undertake a broad study of the future of hospitals with grants totaling more than $100,000 from the A.H.A., the Commonwealth Fund, the Kellogg Foundation and the National Foundation for Infantile Paralysis.

Isbell Is New Chief for Institutional Users, O.P.A.

By EVA ADAMS CROSS

WASHINGTON, D. C.—Marion W. Isbell, Chicago restaurant man, was appointed chief of the institutional user and restaurant branch, OPA, on May 9. He succeeds Kris Bemis who is joining the staff of Walter F. Straub, the director of the Food Rationing Division of O.P.A.

"I am interested primarily in doing a good job and giving satisfaction to everybody within the limitations of food rationing," Mr. Isbell said forthrightly in an exclusive interview granted the Washington representative of THE MODERN HOSPITAL.

"I have been close to food problems for a number of years," Mr. Isbell added, "and in the difficulties arising with food rationing I have suffered right along with every other restaurant operator or hospital administrator."

With the assurance of the seasoned business man, Mr. Isbell is already grappling with the problems arising from the new amendment to G.R.O. 5 which provides for a 50 per cent cut in the value of ration stamps. This cut in ration value has worked hardships in numerous hospitals because of the peculiar meat situation at the moment, he explained.

The problem is currently being studied with the idea of remedying the difficulties entailed in the new amendment as quickly as possible, declared Mr. Isbell.

Order Coal Now

WASHINGTON, D. C.—Donald Nelson urges all consumers to place orders for coal without regard to their seasonal requirements and to stock this summer's coal supply to the maximum amount established under Solid Fuels Regulation No. 10. A serious deficit, which the manpower shortage in mines may make even more acute, has been forecast by the Solid Fuels Administration for War.

United Medical Services Formed in New York City

Community Medical Care and the Medical Expense Fund, both of New York City, have been merged to form the United Medical Services, Inc., to provide prepaid medical insurance for the lower and middle income groups of the New York metropolitan area. Sale of the contracts will be handled by the Associated Hospital Service of New York, thus offering a package plan. The new merged organization has been approved by the house of delegates of the Medical Society of the State of New York.

The state medical society also voted to set up a bureau of medical care insurance with a full-time director to study possibilities of a state-wide plan directed and controlled by the society. The service is designed to meet the costs of catastrophic illnesses in the beginning but may be extended later.

The United Medical Service has 44,200 subscribers. Income limit for full coverage is $2500; above that the plan offers medical expense indemnity only.

Red Cross Appoints Negro Nurse

WASHINGTON, D. C.—The first Negro nurse to be appointed to the American Red Cross Nursing Service is Mrs. Marion B. Seymour who was released by Freedmen's Hospital May 15 for a six months' period. Mrs. Seymour, assistant director of nurses at Freedmen's, is one of the 18 Negro nurses of the first World War. Mrs. Seymour will study nursing service programs for the purpose of planning broader extension of such programs among Negroes.

Science Writers Named Consultants

WASHINGTON, D. C.—Five science writers have been named as civilian consultants to Surgeon General Norman T. Kirk of the Army. Their chief function will be to help acquaint the public with the latest developments in Army medical research. They are David Dietz, science editor, Scripps-Howard newspapers, Cleveland; James C. Leary, science editor, *Chicago Daily News;* Robert D. Potter, science editor, *American Weekly,* New York; Lawrence C. Salter, associate director of press relations, American Medical Association, Chicago, and William L. Laurence, science news editor, *New York Times.*

Progress Reported at Pan-American Health Parley

By EVA ADAMS CROSS

WASHINGTON, D. C.—The fifth Pan-American conference of national directors of health opened a week's session here April 22 with medical representatives from all the American republics in addition to delegates from Dutch Guiana and Curaçao.

The United States was well represented with members of the U. S. Public Health Service, the U. S. Army and Navy, the Office of the Coordinator of Inter-American Affairs, and observers from various unofficial institutions interested in Pan-American health problems, including the Rockefeller Foundation, the Commonwealth Fund, Pan-American Airways and others.

A review of the reports submitted from the different Latin-American countries shows that the most outstanding recent developments in public health in the hemisphere included: emphasis on nutrition; increased attention to specialized training of public health personnel; the creation of schools of nursing in many countries; extension and improvement of basic sanitary services; a great movement for hospital improvement and expansion, together with construction of such institutions as tuberculosis and leprosy sanatoriums, and the undertaking of many large scale programs of malaria control. International control of drugs and medicines, air navigation, quarantine and immigration were discussed.

Conference Discloses Need for Study of Convalescence, Rehabilitation

How far we have yet to go in the study of convalescence and rehabilitation was revealed in a two day conference on the subject sponsored by the committee on public health relations of the New York Academy of Medicine in late April.

Officials of the various government services, in conjunction with public health heads and hospital administrators, heard the opinions and experiences of some 40 authorities and were in agreement that, despite the fact that certain principles apply to convalescent soldiers as well as to civilians, we need to take advantage of all the research that is being done as a basis for a future program. There is some question, even, whether full advantage has been taken of what knowledge already exists.

The purpose of the conference was outlined by Dr. Oswald R. Jones, chairman of the sub-committee on arrangements. He said, "From the vast experience which our armed forces are accumulating in the field of convalescence and retraining, our civilian agencies should obtain many tried and proved formulas for the care of the people of this country after the war. Specifically, we hope to obtain some scientific medical facts about bodily functions in convalescence that will explain some of the hidden mysteries of the post-illness period."

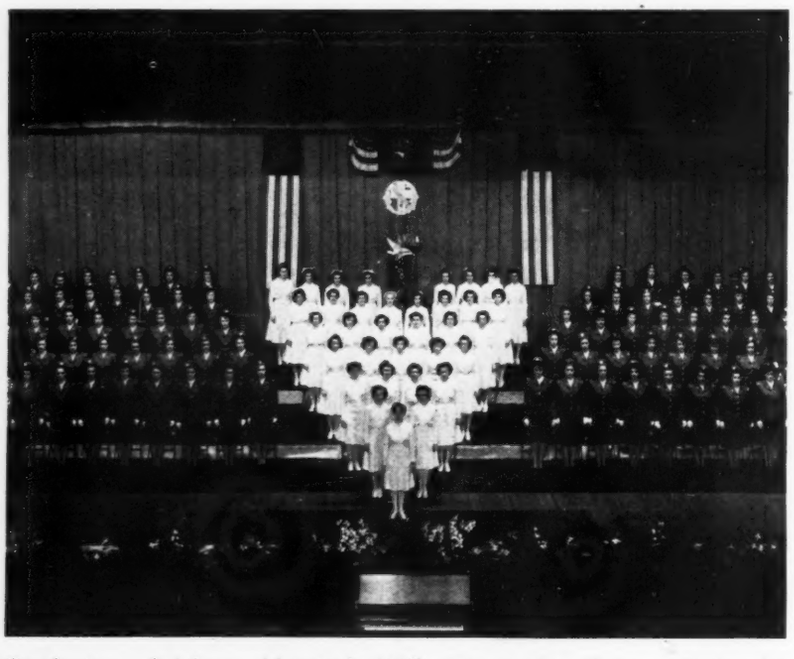
Dr. William S. Tillett, New York University College of Medicine, declared that the more sedentary the patient, the weaker he becomes until his chief desire is to rest. For this reason suitable exercise constitutes a major requirement in the program.

Speaking for the Navy, Capt. Frederick A. Jostes, MC-V(S), outlined the program for that branch of the service as follows: (1) a psychiatric survey which will afford a picture for those who must plan the future and which will show aptitudes, skills and social adjustments necessary; (2) social service and religious counseling carried on by the Red Cross and chaplain's service; (3) a study of the physical defects which will tell whether the patient suffers from the defects of locomotion or needs plastic repair; (4) continued maintenance of physical fitness, which will include exercises at specified times in the wards, massages and diversional activities, including music, in which all can take part; (5) physical therapeutic measures which include new methods of producing movement in long disused parts; (6) occupational therapy and recreational measures which should arouse the patient's interest, courage and confidence in order to overcome his disability; (7) recreational activities, including games, motion pictures, music, arts and crafts, and any sort of activity that will create social contacts; (8) prevocational training and guidance, the aim of which is to assist those who are returning to civilian life to find an occupation to which they are suited, and (9) correlation of all agencies interested in civilian adjustment, such as the Red Cross, Veterans Administration, educational service officers, occupational therapy organizations and community representatives.

Similar presentations were made on behalf of the U. S. Public Health Service, the Army, Office of Vocational Rehabilitation, Veterans Administration and Army Air Forces.

The need for close relations between hospitals and convalescent institutions was emphasized by Dr. Herman A. Zazeela, Neustadter Home for Convalescence, Yonkers. Among other suggestions Doctor Zazeela urged an interchange of trustees, with the hospital director serving as consultant in the direction of the home.

This symposium is the second of its kind to be held by the New York Academy of Medicine. The first conference on this subject took place in November 1939.



Graduates of Mercy Hospital, Wilkes-Barre, Pa., form a living V, flanked on either side by uniformed students, at graduation exercises held on April 28. The 34 graduates are members of the cadet corps.

How Senior Cadets Are Cleared for Federal Jobs

WASHINGTON, D. C.—A clearance procedure for senior cadets requesting appointment to one of the five federal services has been established by the U. S. Civil Service Commission. The commission acts as a pool for the federal services only.

A check is made by the commission to see that the school of nursing is approved by its state board of nurse examiners. Applications are then sorted according to the student's preference. Applications are reviewed at the Civil Service Commission headquarters by representatives of the federal nursing services.

A cadet's eligibility is determined by the federal service to which she has applied. Her scholastic standing is a major deciding factor. Physical requirements and specific requirements of the service to which she has applied must be met. If a cadet fails to meet the requirements of the service of her first choice, her application is returned to the commission where it is referred to the applicant's second choice. If she should be rejected by all the services she has listed, the school of nursing is notified.

Applications should be sent in from three to six months before the junior cadet training period terminates. All forms received by the school must be returned together. The cadet is asked to give serious consideration to her first choice to avoid the delay and confusion of last minute telegrams and letters asking that a change be made.

As of May 1, the commission had processed approximately 3000 applications. Of this number, some 2000 were turned over to the federal services. The Army accepted 799; the Navy, 534; the U. S. Public Health Service, 21; Indian Service, 31.

Occupational Therapists Needed

WASHINGTON, D. C.—The U. S. Civil Service Commission is calling for occupational therapists to aid in the rehabilitation of injured soldiers returning in increasing numbers to veterans' hospitals. Experienced graduates of accredited occupational therapy schools are sought. Though therapists are preferred with experience in hospitals approved by the A.M.A., some positions may be filled by persons with college training in psychology and in arts and crafts or trades and industries. Experience as a junior aide in veterans' hospitals may be substituted for training in occupational therapy schools. Some positions may be filled by inexperienced graduates of such schools.

Service Awards Given Chicago, New York, St. Louis Volunteers

Its 224 volunteers, including Gray Ladies, nurse's aides and dietitian's aides, were honored at a tea given May 6 by the board of managers of Presbyterian Hospital, Chicago. Awards to those who have given a minimum of 50 hours of service to the hospital were made by Charles B. Goodspeed, president of the board.

Sleeve insignia were given to 50 women who have served for at least fifty hours, and special service bars were awarded to 10 who have served in the hospital for a year, with a minimum of 200 hours during that period.

In Greater New York the United Hospital Fund arranged four meetings for the presentation of awards to 3500 men and women volunteers for from 150 to 1500 hours of contributed service. The meetings were held in New York City, Brooklyn, Queens and Richmond.

Included among these volunteer aides who have served 150 hours or more were approximately 500 men; last year there were only three.

The community service award presented annually by the Hospital Council of St. Louis this year went to the St. Louis Chapter. American Red Cross Nurse's Aide Corps. Nearly 1500 nurse's aides attended the ceremony held on May 8 and received 1500 individual certificates of honor. A special certificate was presented by H. J. Mohler, president of the council, to Mrs. Ernest G. Ross who has given 2000 hours of service as a nurse's aide.

H. J. Mohler presents certificate of honor to Mrs. Ernest G. Ross.

Hospital Organizations Not Consulted on Penicillin Depots

WASHINGTON, D. C.—The Office of Civilian Penicillin Distribution established in Chicago under Dr. John N. McDonnell as director will handle the civilian distribution of this still limited drug, the chemicals bureau of W.P.B. announced May 4.

More than 1000 U. S. hospitals have been selected by an advisory panel, including representatives of W.P.B., the U.S.P.H.S. and the American Medical Association, to serve as depot hospitals for penicillin. These depot hospitals will furnish the drug to other hospitals when their need is established, the supply on hand being also a determining factor.

Neither the A.H.A. nor any other hospital organization was represented on the committee which chose the depot hospitals. The list has been given widespread publicity and the good hospitals omitted have expressed considerable dissatisfaction at the erratic selection shown. Some report that the public has accepted their omission as indication that they are second-rate institutions. The list is subject to revision by the advisory panel.

For the guidance of physicians who may wish to use penicillin, the War Production Board has published a summary of a survey on the drug. The survey was prepared by Dr. Chester S. Keefer, who, as consultant to the committee on medical research of the Office of Scientific Research and Development, has been in charge for nearly two years of the civilian distribution of penicillin. His report is based on a study of more than 3000 cases.

Hospital Activities of Budget Bureau Are Consolidated

WASHINGTON, D. C.—Effective May 1, Harold D. Smith, director of the bureau of the budget, consolidated the hospital activities of the bureau into a single administrative unit designated as the hospital section, consisting of an estimates group and a management group.

Fred A. McNamara, formerly chief of the business management section of the Division of Administrative Management, has been appointed chief of the hospital section. Harry H. Graef Jr. has been designated as head of the estimates group and Leroy D. Gifford as head of the management group.

The organization of this segment of the bureau's work on a functional basis is designed to enable the bureau to deal more effectively and constructively with the budgetary requirements, management problems and operating programs of the federal system of hospitals which at the present time comprises nearly one thousand hospitals in the continental United States operated by eight federal agencies.

POSTWAR PROPHECIES

By

HUGH CABOT, M.D.

VANE M. HOGE, M.D.

DOROTHY ROGERS WILLIAMS, R.N.

NELL CLAUSEN

Doctors or Trustees—*Which?*

HUGH CABOT, M.D.

THIS is an appropriate time to survey the position in our economy of the voluntary hospitals and to attempt some estimate of the plans that must be made and the courses that must be plotted if they are to play their full part in our changing economy. I am including under the term "voluntary hospital" only those nonprofit institutions that have been supported by private contributions and have been "private enterprises" as distinguished from the hospitals that are primarily tax-supported.

Although it is not evident that their governing boards are always aware of the fact, these hospitals are a focal point around which the only too evident demands for improvement in our distribution of medical care can rally. There is imminent danger that, unless these great institutions undertake responsibilities which they have not previously exercised for drawing together the component parts of medical service, small groups whose rôle in the whole problem is important—even essential—may, in the mad scramble to preserve their private interests, bring the whole structure down about our ears.

What appears to me to be needed at present is not beneficent inattention to the struggle for position of the various groups that constitute the whole of what we call the voluntary hospital, a struggle certain to be strongly motivated by self-interest, but rather a broad survey of the position that these hospitals have occupied and a clear statement of their potentialities for the future.

Problems Have Altered

Looked at from the perspective of a century or more, these voluntary hospitals have, besides caring for the sick, been social and scientific experiment stations. In a still broader sense they have followed the pattern of social development, under democratic conditions, by which private groups of intelligent and well-disposed persons have experimented with social developments which, if they proved to have large elements of permanency, were ultimately incorporated into the structure of the society.

One cannot avoid the conclusion that hospitals now occupy, or can occupy, a commanding position in the medical, social and economic problems involved in the growth and distribution of modern scientific medical care. In the development of medicine, in education—in both medicine and nursing—and as training centers they have reached their highest distinction. They have achieved this distinction because they have led, not because they have followed, public opinion.

On the other hand, although hospitals have made progress, this progress has not been rapid in meeting the changing social and economic problems of the community in the distribution of medical care. It is true that the establishment of social service as an essential part of the hospital organization showed comprehension that a hospital should be something more than a medical repair shop.

The development of these services, however, has been beset with difficulties and has met with considerable resistance from those who continue to believe that the medical, rather than the social, interests of the hospital must not only dominate but control.

Basis of Support. It was inherent in their origin that the voluntary hospitals should be regarded by the community as charitable institutions that drew their support from the contributions of well-disposed persons with excess income. Their managing bodies have been largely constituted of successful and influential people believed to have access to the coffers of the rich. It is in no way surprising that this should still be the dominant conception of the sources of their support, even though the premises upon which this conception was erected have almost completely disappeared.

In the first place, the voluntary hospital of today is only partly, and sometimes only slightly, the refuge of those who must seek charity. Since the community has recognized the hospital for what it is, the demand upon its services comes today from all income levels and a large moiety of its income is not from charitable contributions but from patients.

In the second place, though here there will be less agreement, our whole conception of the place of charity in the distribution of medical care has changed. Only a part of its patients can, by any stretch of the imagination, have the degrading adjective of charity properly appended to their classification and the time is overdue when we must redefine the use of this term.

I suggest that it may be appropriately confined to those members of the community with whom Dame Fortune has dealt unkindly and who are temporarily unable to hold their own in a rapidly changing society. The number must be small if democracy is to survive. To this will probably have to be added a category of people who, through the inadequacies of our present knowledge, are crippled, perhaps permanently, by chronic disease. They must often become wards of the state.

However, the group thus covered would be a far cry from those now included as "charity patients" because, forsooth, they cannot pay the high price of modern scientific medical care. This category may easily include, in one way or another, something like half the population. There are, even, families with good incomes—$3000 to $5000—that, when faced with medical catastrophe, must accept "charity" from someone, either the hospital or the physician. The great middle class with annual incomes of from $2000 to $3000 is often put to it to pay the necessary cost of modern scientific medical care. At least half of this group must now accept "charity" or second-rate care.

Morton Hospital, Taunton, Mass. Photographs by William Rittase.

The burden of charity does not belong on the modern hospital.

Finally, there is a large segment of the community, which may approach something like one third, which, though capable of satisfactorily providing itself with the so-called "necessities of life," food, shelter, clothing, is quite unable to pay for the benefits of modern medical care which will not only look after it in disaster but see to it that its health is ensured through the application of modern preventive medicine. These people are now classified as "medically indigent," a polite term to cover the fact that they are a charge against the community.

I submit that, with the extraordinary advances in preventive and curative medicine, medical care has risen to a parity with the so-called "necessities of life." In fact, a good argument could be made for the proposition that without such health as modern medicine can provide the other so-called "necessities" may be a hollow sham. A democratic society will not much longer beg for the decencies of life.

Returning now to the financial support of the voluntary hospital of an earlier day, namely, the excess income of well-disposed persons, we find that it has rapidly diminished and is, in fact, approaching the vanishing point. In the past the hospital, through the good offices of its managing board and its seductive appeals to the public, was, in fact, levying a private income tax on the higher income brackets. But the advent of federal and state income taxes has gone far to produce a situation where there is no excess income. Moreover, such sources as remain may be regarded as oversights on the part of our harassed brethren of the House Ways and Means Committee, and such oversights cannot be depended upon to continue.

In a word, the voluntary hospital has been required, more and more, to depend upon income from non-charity patients to carry its charity load. If we will recall that to the persons entitled to charity under the older classification must now be added the medically indigent, the problem of financing on this basis approaches the insoluble. Either the well-to-do must be grossly overcharged or those who cannot pay will be neglected. Obviously, here is a situation at which we can no longer blink.

Medical Organization. The medical organization of many hospitals still reflects conditions that have long since ceased to exist. In the days before the full development of modern scientific medicine the great hospitals were chiefly staffed by physicians who had won their spurs in

competitive medicine and achieved a reputation in the community. For them the hospital served as a place where, because of the considerable numbers of people who sought refuge there, opportunity was presented to observe such people — cases — in great numbers and to see examples of rare diseases that they might not otherwise meet.

Since the time-consuming business of adjusting complicated laboratory findings with clinical symptoms did not exist, the demand upon the time of these gentlemen was not excessive. The coat-tail visit, which amounted simply to "entering an appearance," was common enough and perhaps served some purpose, though God knows what.

All this belongs to the past. Modern medicine takes time, and effective management of either indigent or private patients cannot be satisfied by the coat-tail method. But this increase in the time requirements has not been met with an increase in compensation.

In the old days the physician's compensation was in experience and added reputation. But today if these gentlemen are to be compensated for the time they must devote to do the job properly then experience and enhanced reputation will fail disastrously and they will either neglect their work or land in the poorhouse. Obviously, their time must be paid for, which will still further complicate the problem of hospital financing.

This is not the whole story, however. The modern physician without access to a modern hospital is deprived of half his usefulness. In fact, he cannot distribute modern medicine at all. From this it follows that every physician licensed by the state must, in some way, be associated with a hospital or offer an inferior grade of work. Here is another problem facing the managing boards.

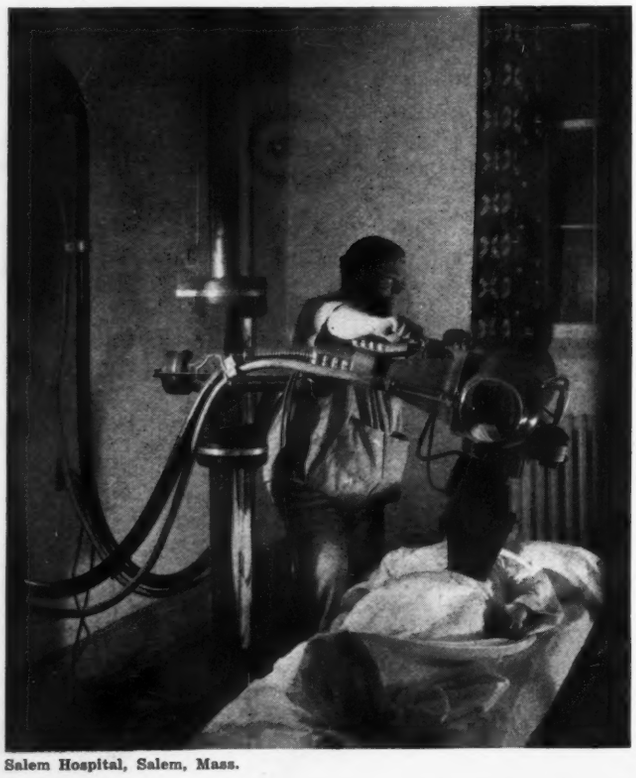
Finally, we must admit that hospitals have, almost of necessity, been organized to suit the convenience of their medical staff. But, since the hospital has become the refuge of the whole population when faced with complicated medical conditions, one might venture the suggestion that, as the center of gravity has shifted, the management will have to pay more attention to the rightful demands of the patient and less to the idiosyncracies of the visiting staff.

Teaching and Training. Since all are agreed that the education of those who must carry the professional burden of medical care is an important duty of the hospital, we shall have to see to it that teaching is not neglected. Any method that profoundly reorganizes the distribution of medical care through hospitals must keep in the forefront of its calculations the proper development and nourishing of teaching hospitals. These are, today, almost a group apart, though in the metropolitan districts most of the hospitals have some teaching assignment.

For their development I think we can lay down the specifications. They must be intimately attached to or associated with universities. Their teaching staff must be selected for teaching and proved technical ability. They must be amply supplied with patients and their staff will tend to be on an academic basis.

Because one of the most important teaching functions of the hospital is in the nursing field, changes will have to take place here. I have elsewhere[1, 2] expressed my view that nursing education will have to be importantly changed if it is to keep step with the requirements of modern health service. The curious anomaly by which nursing education is still largely on the apprentice basis and under which the students are paid, though in trivial amounts, can hardly continue much longer.

There is no logical reason why nursing education should remain a thing apart from other forms of education for which somebody, either the parent or the taxpayer, must provide funds. I am aware that this will require extensive reorganization of the conduct of the hospital but it seems to me inevitable and I think we ought to face it.



Salem Hospital, Salem, Mass.

One of the difficulties hospitals must face is opposition from organized medicine to the inclusion of what have been regarded as laboratory services under Blue Cross payments. An outstanding example has been the attempt of the roentgenologists to make their own charges at their own rates.

Chances for Survival

Although to many, who see only in these great institutions their importance and their really magnificent contribution it may seem ridiculous to question the survival of the voluntary hospitals, I think the survival of the voluntary hospital is a fair question, taking into consideration the existing conditions of the hospitals of the world and the changes in our society that seem to me certain and imminent.

It may be recalled that the charity, more recently called voluntary, hospital is largely an Anglo-Saxon institution. Generally speaking, the hospitals of Europe and other so-called civilized countries have been government or tax-supported. In England, during the interval between the

[1]Future of Nursing Education, The MODERN HOSPITAL, **60**:47 (Feb.) 1943.

[2]The Place of Nursing in Health Services, Public Health Nursing, April 1943.

World Wars, the position of this group of hospitals became increasingly precarious.

Almost without exception, they were unable to survive on the basis of voluntary contributions and required increasing government support. During the same period they were menaced by the growth of the great tax-supported County Council hospitals with their salaried medical staffs.

The comparison is not quite apposite, since the voluntary hospitals of this country have depended much less upon voluntary contributions and have often been supported chiefly by payments from patients. Nevertheless, the threat is similar and there is a lesson to be learned.

This lesson is, bluntly, adaptation to changing conditions, social and economic. The adaptation required will be chiefly in two fields: (1) methods of financing; (2) ability to take their place as keystones in better methods of distributing medical care.

Methods of Financing. Obviously, these hospitals must have adequate financial support or be taken over by government, since the continuance of hospitals is not to be questioned. As has already been suggested, voluntary contributions cannot be counted upon as an important source of funds. The alternative would appear to be some method by which all patients pay for their care at a rate commensurate with the service supplied. Roughly speaking, the patients may be thought of as in three groups:

1. Those able to pay for their service — and they should do so, though they should not pay for anybody else.

2. Those who cannot pay out of current income or savings.

3. A group, which under sound economic conditions should be the smallest, which cannot pay by any method of financing and for which payment must be made out of taxes.

With the first group we need not be here concerned.

For the second group the problem is soluble through the application of the insurance principle. The recently developed Blue Cross plan has achieved relative success because it applies the sound principle that modest contributions from large groups will, in the long run, enable the well to pay for the sick. If this principle can be sufficiently extended it may solve the problem of hospital financing for the majority of the patients.

Whatever view may be held of the place of charity in a modern democratic society, I suggest that the burden does not belong upon the voluntary hospital except for accidental situations. At the present time, acute illness among those unable to pay is often treated in tax-supported hospitals. This may be the best solution, though I doubt it.

Another method, following the view that all citizens are entitled to good medical care, would involve reimbursement, by the community or some larger political entity, of the voluntary hospitals for this group of patients. I do not now press the point further because it seems to me to involve large and complicated economic questions which we are not, as yet, prepared to face.

Keystones of Better Distribution

The great change which the voluntary hospitals, together with other groups in the community, must face and to which they must accommodate themselves or perish flows from the fact that modern scientific medicine cannot now be distributed as was the empirical medicine of the past. Medical practice is, today, not an affair of individuals but an affair of groups. The individual patient, dealing for most of his medical care with the individual physician, will get but a shoddy article likely to be expensive at any price.

We must work out a method by which groups of individuals are cared for by groups of physicians, since in no other way can the possibilities of modern medicine be reasonably well distributed. This still disputed assertion should come as no surprise to those who have been responsible for the magnificent development of our hospitals.

For practical purposes, it is here that group medicine has grown and been nourished and the present high offering of these institutions is due almost wholly to this fact. Thus, they have behind them the proved success of half a century.

The only fly in the ointment is that, up to the present time, the benefits of hospital group practice have stopped short at the charity level and the benefits have been but slightly available to so-called private patients. It is at this point that the voluntary hospitals will show their comprehension of modern conditions and lead the way or tag along and take the consequences. Obviously, modern medical care will have to be distributed from centers. Either the voluntary hospitals will accept the challenge or the job will be taken away from them. They have the power. Have they the courage?

One sees some suggestion of the difficulties that they will face in the discussions of recent years in regard to the scope of coverage of the Blue Cross. Organized medicine, although it obstructed the Blue Cross at the beginning, has fallen into line since the plan has obviously operated to increase the income of physicians. In the past, hospital bills often became so burdensome that there was little left over for the physician.

Today, on a prepayment basis for hospital care the physicians' collections have increased but they want still more. There has been increased opposition to the inclusion of even what have been regarded as laboratory services under the payments of the Blue Cross. The worst example has been the attempt of the roentgenologists to make their own charges at their own rates.

Here is the crux of the situation. Either the physicians will control the hospitals and dictate their policies, in which case survival will be unlikely, or the managing boards will assert their authority in the public interest and the voluntary hospitals will survive and prosper.

Reorientation May Be Needed

I shrewdly suspect that the solving of these questions will involve some reorientation of the managing boards. In the past they have tended to represent a small group in the community that was the chief support of the charitable aspects of these hospitals. In the future, they will, I think, have to represent their clients, the patients, and thus become more sensitive to the changing opinions of a modern world. The days when hospital trustees could properly conduct these great social institutions by devoting to them their spare time are about over.

Perchance, the managing board of a voluntary hospital should consist of a reasonable number, say a dozen, of long-headed, judicious, representative folk, specialists in nothing but a knowledge of the world in which they live. Such a board should have

as its advisers three standing committees, the chairman of each being a member of the board and the secretary of each being the administrator of the hospital.

One committee might deal with social problems and should draw upon the experts in this field. Another committee might deal with financial questions and should number among its members people skilled in extracting money from a bewildered community. Certainly, there should be a medical committee consisting wholly of physicians, chiefly members of the staff. On all professional questions their opinions should be controlling but, unlike present day conditions, in fields social and economic their opinion should carry only such weight as their chosen field might warrant.

I am aware that this is an oversimplification of an enormously complicated problem. If it should provoke thought and discussion it will have served its purpose.

Blueprint for Postwar Building and SERVICE

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ONE hears much about postwar planning these days and it is evident that all types of health facilities have an important place in these plans in the minds of the people. It is a common assumption, too, that these much discussed postwar plans will involve, in one way or another, some form of federal participation.

With or without federal assistance, however, it is an absolute certainty that the immediate postwar period will see a vast amount of construction involving all types of hospitals, public health centers, diagnostic centers and allied facilities. Various careful estimates have placed the cost of these facilities needed in the first postwar decade at upward of $3,000,000,000.[1]

The facilities needed fall under several well-defined categories. The needs are for new general hospitals, especially in rural areas, and for the replacement of those that are obsolete and for new mental and tuberculosis hospitals and for the replacement of those that are obsolete. In addition, two other types of health facility, heretofore relatively unimportant, promise to assume great importance in the postwar period. They are institutions for the care of the chronically ill and public health centers.

How to care most efficiently and economically for the chronically ill is one of the current unsolved problems facing the hospitals and the communities today. Since the number of aged persons in the population is rapidly increasing, this problem will inevitably become much more acute. Special facilities in which to handle these chronic illnesses of advancing age seem certain to be an important postwar necessity.

Health Centers Are in the Picture

Health centers in their present conception and future development will be an important feature in the postwar health picture. The need for this type of facility has been accumulating over the years, during which time the science of public health and preventive medicine has made great technical advances but has been sadly handicapped in its application by facilities and surroundings that are hardly short of disgraceful.

Any postwar hospital construction plan would be unworthy of the name if it did not involve more than blueprints for building. It must also involve blueprints for service. It has been said that the hospital is the keystone in the arch of national health. If that is true, public health and medical care are the two supporting pillars. Certainly the health structure is mainly composed of these three elements and no one of them is sufficient unto itself.

If this is the relationship of the hospital to national health, it follows that hospital service must be brought to all the people. The expression is often heard that "the hospital is the doctor's workshop." It should be much more than that.

It is reasonable to assume that the hospital performs as valuable a service through its influence on the quality of medical care to patients outside its doors as it does through treating those within its doors. Certainly, doctors of the present generation will not settle where they do not have ready access to reasonably good hospital facilities. This fact alone is one of the major factors in the uneven distribution of doctors throughout the country.

If a sound health structure rests upon a proper distribution of hospital and clinic facilities, a way must be found to make them function effectively. We are all familiar with the difficulties surrounding the operation of small hospitals. Costs are likely to be high and the quality of service is too often low.

In the small hospital it is often especially difficult to maintain proper laboratory service, such as pathological diagnosis, interpretation of x-ray films, electrocardiographic readings

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Presented at the Hospital Association of Pennsylvania, Pittsburgh, April 13, 1944.

[1]Mills, Alden B., and Sanford, Russell T.: "Civilian Hospital Needs in the Postwar Decade," The MODERN HOSPITAL, October 1943; Hoge, V. M.: "Add Two Billion for Hospitals," Hospitals, December 1943.

and other more difficult tests. In the small isolated hospitals, too, the services of competent specialists cannot readily be obtained. Obscure conditions are likely to go unrecognized and untreated.

How, then, is this wide distribution of facilities to be achieved? Obviously, only through organization, coordination and cooperation. Several proposals have been heard recently suggesting means by which this problem may be solved. While these proposals differ in detail, they are basically the same in that they visualize facilities graduated in size and scope of service according to the size of the community they are to serve but with an equalized quality of service.

All the proposals embrace three types of units. The first is the large primary teaching hospital; the second is the secondary service center, and the third is the small rural hospital or health center. The broad objective is established channels for the dissemination of medical skill and services.

Within the framework of these proposals an infinite variety of modifications to meet any local circumstance would be possible. For example, the administrative relationships might range all the way from nominal to absolute, as would be the case if a large hospital saw fit to set up a small outpost branch. Ordinarily, however, we should expect to see the smaller hospital retain complete administrative autonomy.

The primary teaching center might be one or more university hospitals within the state, or several qualified teaching hospitals might serve in this capacity. In states having a sufficient number of teaching and secondary service centers no tertiary center may be required.

These proposals are not academic daydreams. A program involving the fundamentals of the plan has been in operation in Maine for several years. The success of the plan in elevating the quality of rural hospital and medical care has been amply demonstrated and has been extremely satisfactory to all concerned.

At least one southern state has already laid the groundwork for a plan that will ensure hospital and diagnostic services to all parts of the state. Briefly, the plan calls for the establishment of a fairly large hospital of several hundred beds in connection with a state university. In addition, a number of smaller secondary institutions will be located at strategic places throughout the state that will have a direct administrative connection with the parent institution. The existing and future smaller voluntary and county hospitals will constitute the third link in the chain.

While the state and local governments would discharge their obligations to the indigent and medically indigent through this institutional network, the facilities and services would be equally available to private patients. The purpose back of this plan is well expressed in the governor's message transmitting the proposal to the trustees of the state university:

"There is grave concern on the part of all members of the medical profession in all its various branches over the prospect of what is broadly termed socialized medicine. Bills are now pending in Congress which in the opinion of the profession and of many thoughtful laymen would strip the medical profession of many of its noble and traditional attributes, deprive patients of the time-honored privilege of personal selection in the matter of medical service and subject the whole field of medical practice to the uncertain and unsatisfactory manipulations of politics.

"While such prospect is naturally viewed with apprehension, it is at the same time fully recognized by the profession that certain broad and deep trends in the field of social welfare as affecting medical service cannot and should not be resisted. These conditions spring from a deep-seated feeling that good health and adequate medical attention should be the right and privilege of every man, woman and child, regardless of race, condition or financial circumstances.

"It is manifest that we cannot attain to that high degree of health essential for national well-being and economic prosperity if adequate medical service is limited only to those who are financially able to pay for it.

"In many instances great industries have recognized the wisdom of this course and have under cooperative arrangements set up plans whereby the humblest employe can obtain adequate medical attention without being called upon to bear the financial burden. However, a large segment of our population cannot obtain the benefits of such individual arrangements which can only apply to those engaged in such industries."

It is noteworthy that the medical society of this state is back of this proposal, both as a means of giving better service and as a preventive measure against so-called socialized medicine.

In view of the magnitude of the planning and construction job that lies ahead, a heavy responsibility rests with the group responsible for the nation's health. If the millions that will be spent for health facilities are to return full value in service, they

SUMMARY OF POSTWAR SPECIFICATIONS

Specifications of our postwar hospital construction blueprint call for:

1. A state health planning committee representing the hospitals, the medical profession, the public health services, the architectural profession and such representatives of the general public as may be deemed necessary.

2. Based on a comprehensive survey, a program of hospital and health center construction and improvement, to the end that all parts of the state shall be adequately served.

3. An estimate of the total capital cost and the probable allocation of costs.

4. Plans whereby the standards of small hospitals can be maintained through service connections with larger institutions.

5. A state agency to administer grants-in-aid and other federal programs concerned with hospitals and to carry out the program of the state planning committee.

6. A state advisory council with representation similar to that of the planning committee to assist the state agency in carrying out its program.

must be spent according to a carefully worked-out program.

We all remember the accelerated tempo of hospital construction following World War I which reached its peak at the end of the first decade and dropped off by the loss of 724 institutions by the end of the second decade. This terrific waste of effort and money must not be allowed to happen again.

How can it be prevented? Only by advance planning and a measure of control. Although the very word "control" is anathema to the average American, it must be remembered that hospitals are quasi-public service institutions. They are the only large public service activity that is almost entirely free of official regulation.

Standards Must Be Set

Such freedom can be retained only through voluntary regulation designed to eliminate waste and inefficiency and maintain adequate standards. This apparently could be accomplished to some extent by the enactment of uniform state licensing laws. Such regulations not only should assure reasonably adequate standards but also should prevent the building of unnecessary and substandard institutions.

Any intelligent attempt to control and guide postwar building must be preceded by a carefully programmed plan. Such a plan should encompass a survey and evaluation of all existing hospital and health facilities. The plan should indicate where existing facilities should be increased, improved or replaced. It should indicate where new hospitals should be built and the chronological order of construction based on relative urgency.

The plan should indicate, too, the estimated capital cost of the improvements and the probable source of the funds. It should indicate also the proposed methods of operation and maintenance.

Such a planning job is clearly no small undertaking. To whom should it be entrusted? Many states have now set up or are in the process of setting up state planning boards or commissions. Each of these boards should have a special committee concerned with health and hospital facilities. Where no over-all state planning board is contemplated, a special health planning committee could serve equally well.

Membership on a health planning committee should include a representative of the state's hospitals, of the state department of health and of the state medical association. Since an estimate of cost must imply some uniformity of architectural standards, a competent architect should be a member of the committee. The public, too, should be represented through such individuals as the state authorities may decide. Such committees should have official state agency status.

Who Will Pay the Cost?

Where will the estimated $3,000,000,000 needed for new construction come from? Much of it should, of course, come from the communities receiving the facilities. However, many or perhaps most of the communities in the direst need of facilities are financially unable to raise a substantial part of the capital cost. If anything like complete coverage is to be obtained, it seems apparent that some state and federal aid must be forthcoming.

Should any such program develop in the future, hospital administrators and the rest of the citizens of this country will determine how it is to be handled. The importance of this decision can scarcely be overestimated; it may, to a great extent, influence the future course of hospitalization.

We already have several established patterns of federal, state and local relationships. Let us examine some of them. The depression years saw a number of hospitals built by the Public Works Administration. The primary object here was to create employment. The resulting product, however valuable, was of secondary consideration. Under this program the local community or sponsor was required to provide 45 per cent of the cost. Under these conditions the more needy communities were unable to benefit from the program.

It is noteworthy that this was a direct federal-local relationship. It should be remembered, too, that no professional agency, either federal or state, had a voice in determining the location and scope of these hospitals, their relation to existing institutions or any control over the architectural standards.

Another federal program is the present Lanham Act. Here, again, we have a direct federal-local relationship. There is little doubt that in this program the direct federal-local relationship is desirable since the purpose of the program is to relieve local war-created needs that have relatively little relation to the problems of the state as a whole.

It is significant, however, that here, again, neither scope, location nor architectural standards are controlled by any professional agency, either federal or state. It should be made clear that the relationship of the U. S. Public Health Service to this program is purely consultative and not determining. It has absolutely no legal authority.

By way of contrast, let me cite another example. In 1935, Title VI of the Social Security Act provided annually a sum of money for allocation among the states to further the development of public health services. Allotments are made to the states on the basis of population, wealth and special needs. These allotments are in turn augmented by state and county funds. Within the framework of the law, most of the administrative policies are set by the state health officers themselves at their annual conference.

1835 Counties Served

When the program was enacted, only 762 counties had organized health departments. Now 1835 counties have this service. Plans are now being pushed by the American Public Health Association to cover the remainder of the country through combining the more sparsely populated counties into public health districts.

Public health centers, as mentioned earlier, will doubtless play an important part in these planned extensions. It is to be expected that these public facilities will augment private voluntary facilities, especially in rural areas, by providing modern diagnostic facilities for rural physicians.

Should some type of federal aid program develop after the end of the war, the hospitals must decide what pattern of administration it will follow—whether it will follow one of those discussed here or some modification thereof.

From every standpoint it would seem desirable that any postwar federal aid program should involve state and local participation, not only financially but also administratively.

Skill in bedside care is the very heart of the nursing profession

Morton Hospital, Taunton, Mass. Photographs by William Rittase.

The shape of things to come in Nursing Service

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THE other day I heard of a group of friends who were invited each year to welcome the New Year with their perennial host. Each was required to bring, in a sealed envelope, his prophecy of events to come in the twelve months ahead. The envelopes were placed in a box to be kept under guard until the year was gone. The high spot of the evening came when the prophecies of the previous year were withdrawn from their box and read for the amusement and amazement of all assembled.

It is the courage of those self-appointed soothsayers that has led me to conjecture a possible development of nursing service practice in our hospitals in the years after the war. Certainly, I have no more assurance that my prophecy can be fulfilled, if as much, than have the members of the New Year's party. But present developments and past problems may be used as a guide, though month to month changes make it difficult to see clearly around the corner of the future.

Graduate staff nursing, born of the dual need for protection of the education program for student nurses and for providing good nursing care to the patient, will be as essential a part of hospital nursing service in the days after the war, when graduate nurses are again available, as it was before the call to military service. That graduate nurses have been a rapidly diminishing group during present months has but emphasized rather than depreciated their important contribution.

Twenty-five years of experience with this type of nursing has not removed such oft-recurrent problems as frequent turnover and persistent instability among the group. In the past there was little opportunity for professional advancement, for the stimulus of expanding responsibility or for financial recognition. Staff nurses soon lost interest in their work and sought other fields of endeavor.

It is of real significance that all too frequently a nurse described her service as "just staff nursing" yet the ability to give skilled bedside care to the patient is the very heart of the nursing profession. It is admittedly fundamental to the achievement of the whole hospital field and of paramount importance to its success as a community health agency. Some solution must be found to this problem of long standing; no longer can it be ignored or persistently lamented without positive action being taken on it.

Critically ill patients, of whatever administrative classification, must have skilled and extensive nursing care. In the past, those whose personal budgets could meet such additional strain purchased the services of the private duty nurse. Others, who could not do so, became the serious concern of the nursing director who, somehow, somewhere, must find those precious additional nursing hours. She only hoped she could still maintain the service essential to all her patients and meet the requirements of her student educational program.

When the private duty nurse was desired, she was summoned from the nursing registry and was usually selected because she was next in line on the list rather than because of her particular qualification for the task at hand. As a temporary and courtesy member of the hospital nursing staff, she was free to carry out her professional responsibilities as she deemed best. For the most part she was fully capable of such achievement, but many times the errors or dissatisfaction of patient, nurse and doctor could have been avoided had the nurse had the advantage of well-planned guidance from the nursing service director.

When her patient reached convalescence, the nurse's services were frequently retained long past the

days they were needed. Valuable nurse-power of a skilled worker was sacrificed for the pleasant, but seldom essential, duties of companionship. This practice is hardly conducive to growing professional life or to efficient planning for the best use of available nursing skill.

All of these aspects of staff and private duty nursing are familiar to every nursing director and hospital executive. Their importance lies in their significant proportions in past experience and their implications for future planning.

Volunteers to the Rescue

The achievements of war-time months and years would be futile, as well as discouragingly difficult, if something of value could not be gleaned from the experiences thus forced upon us. A Macedonian cry for help came from hospitals everywhere. To their undying credit, the women of the communities all over this land have come, and are still coming, to volunteer their aid in carrying the daily load of hospital patient care.

At first they came with no other preparation than a sincere desire to help, innate ability and judgment developed in meeting the demands of their personal lives. As the need for helpers in bedside duties grew increasingly urgent, they were given a brief carefully constructed course of organized instruction, sometimes by members of the hospital staff, more frequently by such an outside agency as the Red Cross volunteer nurse's aide corps or the Office of Civilian Defense.

True, the background of education, cultural advantages and maturity of experience enable these volunteers to fit into the intricacies of hospital routines somewhat more easily than did the average ward helper employed in that capacity. But two years of working with this type of volunteered nursing service has demonstrated beyond peradventure that a large part of nursing routine, as well as care of equipment, can well be performed by nonprofessional workers who have had some brief instruction in their work.

To remove from the professional nursing load the time-consuming work of making empty beds or beds of patients not acutely ill and to spare nurses the moments spent in taking temperatures, giving morning and evening personal care and feeding patients who need such assistance are to make a priceless contribution toward balancing fleeting moments with the daily demands of nursing.

Never before had accepted standards of nursing care admitted that any but the graduate registered nurse or a closely supervised student could safely be entrusted with such duties. Necessity made rethinking and replanning imperative—wisdom makes continued use of such knowledge intelligent procedure.

Certainly, there can be no expectation of lessened hospital census in the years ahead. Hospital insurance will draw an increasing number of members to its rolls; therefore, more persons will be availing themselves of hospital services when needed. Present day apartment living of the cities and the small homes of the suburbs offer no additional space to be devoted to sick members of the household, nor is it consistent with good judgment to run the risk of prolonged or complicated recovery by dependence upon makeshift home equipment, when every modern facility needed for good care is available in the near-by hospital.

Hospitalization Will Increase

Less than 10 per cent of babies are now born outside of institutions each year. Doctors of the community are increasingly intent upon hospitalizing all patients who need watchful care that can be given only in the hospital. Therefore, the demand for well-staffed nursing service may well be an accepted need of the future.

These are the problems of the past and the developments of the present. What prophecies do they portend for future organization of staff nursing service? Only the review of events at some distant New Year's stock-taking can answer that question with any certainty. But proposing plans and dreaming dreams is everyone's privilege and is an absolute necessity for those who would avoid past pitfalls or who would be ready for fast-moving changes.

It is acknowledged that one of the major responsibilities of any hospital is that of giving adequate nursing care to patients; therefore, every possible step must be taken to meet that obligation. Adequate care means sufficient numbers of persons to provide needed nursing hours. It means maintaining definite standards and making possible careful direction and development of the nursing personnel.

To be sure, this calls for a generous budget and the corollary of careful planning for expenditures within the department. This implies full-time able leadership and is best accomplished when the nursing service is set up as a separate function from that of the administration of nursing education. If these demands seem heavy they are not insurmountable.

Assuming that the hospital has accepted the demand for a sufficient number of staff nurses to meet nursing hour requisites, the question becomes that of judicious use of those nurses. Most patients will not need more than the average number of nursing hours established for various types of clinical classification by earlier studies. A few will require, and must have, more extensive nursing care.

For patients in private or semi-private divisions an additional charge for additional nursing care should be made. This practice has precedent in the laboratory service of the hospital where certain routine laboratory service is included in the room charge, but when extensive or costly tests are made an extra charge is added.

All nursing service would be provided by the hospital nursing staff and all independent private duty nursing, as now practiced, would be discontinued in the hospital service. Obviously, home care of the sick and post-hospital convalescence would still provide some market for the private duty nurse who chose to continue to function as a free-lance worker.

Junior and Senior Staffs

The staff of nurses on the hospital roster would be divided into junior and senior staff nurses. The first group would be made up of recent graduates and of nurses returning to this form of nursing after long absence. They are less experienced in meeting nursing problems with the full authority of their professional status but are sincerely interested in extending their abilities through the practice of bedside nursing. Their salary and commensurate increments would be consistent with prevailing staff compensation; their

assignment of duty would be that of caring for those patients needing general nursing care.

When a junior staff nurse had demonstrated her ability to handle more complicated nursing problems and to exhibit sound judgment when faced with unpredictable developments, she could be recommended for promotion to the rank of senior staff nurse by her head nurse or departmental supervisor. Such promotion would be dependent entirely upon earned recognition and not upon length of service. It would carry with it increased salary, extended annual vacation and other feasible means of acknowledging demonstrated improved skill.

Senior staff nurses would then be assigned to patients needing extensive nursing care, even to the point of full-time service and for as long as needed. But when the urgency for such generous care of the one patient was passed, the nurse's assignment would be changed to the next person who needed her abilities.

Such use of more-than-average nursing care should be allocated by the director of nursing service or her staff in close cooperation with the clinical physician in charge of the patient and in agreement with the financial provision for this service.

Often, the critically ill patients will be those in the public wards where no personal funds are available for any fees, let alone extra nursing charges. But this is no change from present conditions that make necessary the allocation of a portion of the annual hospital budget to free-care work. Again, the increased income of all hospitals from hospital insurance fees is to be noted as compensation for this financial load.

The third step in making best use of professional nursing service under this proposed plan is that of including among the nursing department employes a sufficient number of non-professional ward aides who have had training in routine nursing care. To them would be assigned the nursing tasks that do not call for professional knowledge for satisfactory performance. Workers in this group would also have such salary and perhaps differentiation of uniform as to distinguish them from ward maids responsible for dusting and other ward housekeeping duties.

It is my belief that in the end budgetary requirements for salary differentiations would be compensated by greater achievement, in less time and with greater effectiveness, by persons whose potential abilities are equal to the scope of their responsibility.

The advantages of such a reshaping of nursing service administrative planning are easily seen. Most important of all is the fact that the patient would benefit. Nursing care would thus be available according to patient needs and under the helpful, watchful guidance of the nursing department of the hospital. It is hardly consistent with good judgment or fair practice for the hospital authorities to declare their intent to give needed nursing care to their patients and then to assign to the nursing department the task of fulfilling that obligation without providing the personnel and means that are necessary to make success possible.

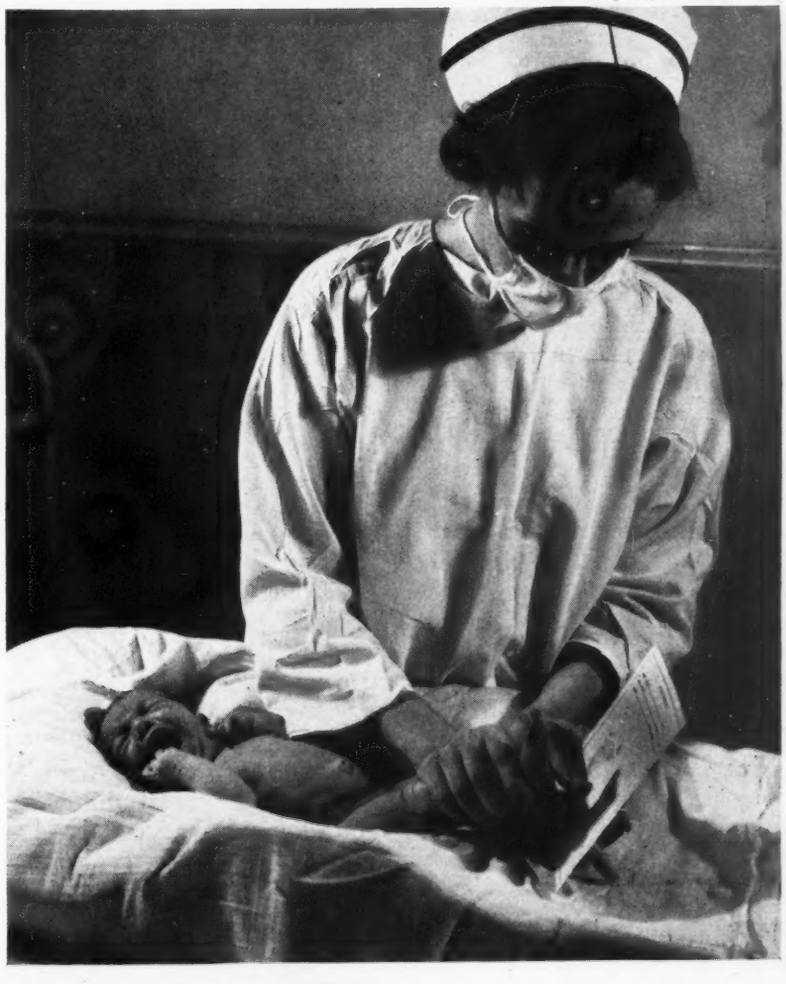
Second, this plan gives dignity and professional recognition to the important fundamental service of staff nursing. It provides incentive to continued service and growth of individual abilities for the staff nurse herself. It makes possible the acknowledgment of the wide experience, additional skill and professional knowledge that the older nurse may bring to her staff appointment.

The private duty nurse seeking a hospital staff appointment would feel that full appreciation had been given the particular abilities developed on her private service, since her promotion to senior staff nurse could be earned after very brief preliminary demonstration. As a staff nurse she would have the stimulus and support of the hospital group activities, plus the challenge of professional work that calls out her greatest efforts.

Third, it makes full use of all available potential nursing ability. To place a skilled worker in a non-skilled task has long been recognized by industry as a costly plan. Work that demands only a portion of attention, that soon takes on the drab aspects of monotony, will rapidly dull the edge of possible achieve-

90 PER CENT ARE BORN IN HOSPITALS

Norwalk Hospital, Norwalk, Conn.



ment—a costly sacrifice when years have been spent in professional preparation.

Putting such a plan into practice necessitates careful administration, complete understanding and acceptance of its principles by all who undertake to put it into effect and totally objective dealing with questions of promotion and recognition. It cannot be accomplished by the director of nursing alone. Neither can it be successful without the aid of well-prepared head nurses and departmental executives. The same demand will be made of any hospital planning of the future, for successful leadership is vital to all constructive progress.

Perhaps all this is only a prophecy but it is a prophecy with a plan.

The Dietitian's Future will be what she makes it

NELL CLAUSEN

Dietitian
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THE future for the dietitian is what she chooses to make of it. The groundwork has been laid by the sturdy and persistent pioneers of the profession through whose efforts the value of the dietitian to the staff of all organizations concerned with group feeding has been established. Dietitians are now in a position to take part in the planning for the hospitals of the future and of other organizations of which they are a part.

First, let us look at the physical setup of the dietary department. It isn't necessary to remind you of the badly located, poorly equipped and inconveniently arranged kitchens of the past (the afterthoughts). Shortage of labor brought about by the war has driven home most forcibly the need of selection, arrangement and care of dietary equipment for efficiency.

There probably isn't one of us who, consciously or unconsciously, is not making postwar plans for changes in our departments. These plans include ample floor space for the department, completely above ground; more storage space for fresh fruits and vegetables; deep freezing units; fluorescent lighting; soundproofing; air conditioning, and adequate office space for the dietitian and her assistants.

New materials are being developed that will increase the sanitation of food service and improve the flavor of foods. Plastic dishes and trays can be completely sterilized and do not impart flavor. Glass-lined coffee urns make better coffee. New precision instruments, automatic controls and more built-in equipment will appear in the dietary departments of the future.

Food conservation programs point out the need for giving personnel some choice in the selection of food and size of servings. We cannot justly demand a "clean plate" if the meal has been handed out without attention to individual taste and capacity—at least not in America with its present level of nutrition and health training. This emphasizes the need for pay cafeterias for the service of hospital personnel as well as for schools and industrial plants.

The present shortage of dietary personnel makes it imperative that something be done about the employe of the future. Salaries have been raised, hours have been shortened, pension plans are being established and employe training courses are being quite generally inaugurated, but that is not enough.

The school systems of this country make it possible for any normal individual to obtain enough education for a white collar job with very little exertion or expense to himself. Something must be done by our profession to remove the stigma from manual labor and recognize the coordination of head and hand. All members of the dietary department must be made to feel that they are contributing factors to the successful operation of the organization. They must be taught the importance of nutrition to effective living and be given credit for their efforts in supplying the essentials of good nutrition in acceptable form. Praise or compliments for the food service must be passed along to them.

Regular meetings with the dietitians at which cooks, waitresses and other employes present methods of food preparation, waste control and other projects in which they are interested, along with those presented by the dietitians, will help. Tours through the institution also create interest. Reports of weight gains or other improvements in the health of patients inspire the dietary employe with a feeling of importance.

This program can be carried out after workers are employed but it is necessary for us to go into high schools, trade schools and vocational schools to sell dietary work to teachers who will, in turn, sell it to students and offer training in preparation for this type of vocation. Otherwise, there will be no improvement in the quality of dietary personnel.

Purchase of food will be simplified for the dietitian of the future for the war has taught that the use of commercially prepared soup bases, concentrates, cake and pudding mixes and salad dressings saves time, labor and money. When the right product is selected it will be of even flavor and quality.

The time is coming when not only content and quality will be stated on package labels but nutritive value will also be listed. Salesmanship will change because the dietitian will demand nutritive value as well as vol-

Presented at the Tri-State Hospital Assembly, May 1944.

ume when she is purchasing foods.

More efficiently arranged dietary departments, better equipment, carefully selected and trained personnel and simplified buying should reduce the amount of detail in which the dietitian of the past has been enmeshed and give to the dietitian of the future more time for supervision.

Factories and industrial plants operating for profit recognize that supervision is necessary to a high rate of efficiency. This is equally applicable to food service units.

Hospitals have never employed enough dietitians to ensure effective functioning of the department over which the dietitian presides and to allow her sufficient time for relaxation and the development of outside interests.

The dietitian of the past has worked long hours and split shifts and, for a professional woman, has drawn a comparatively low salary. Her vocation, avocation and recreation have, of necessity, been dietetics.

The dietitian should plan for herself for the future: shorter hours and a straight shift, living quarters outside the hospital and a salary commensurate with that of other technically trained business and professional women. By her untiring devotion to professional duties in the past, she has made herself indispensable to the hospital and is sought after by many other agencies operating group feeding units or interested in the dissemination of nutrition information. Through her professional organization she has built up standards for service and for training. Only through her own efforts can better working conditions and a higher salary for herself be brought about.

After the war many dietitians will be released from military duty. The market will not be flooded, for between now and that time the demand for more dietitians in hospitals or institutions that already employ a few, in institutions that have not yet employed them, in public health agencies, industrial plants, school lunchrooms, restaurants, trains, ships and airplanes will be so great that those released will be absorbed.

However, this demand was created by the efficient functioning of members of the profession and only by continued increase in our efficiency will this demand keep up. The goal of food service "par excellence" has not yet been reached in all food service units operated by dietitians. Many people still believe there is no such thing as good hospital food—more especially *hot* hospital food.

Salem Hospital, Salem, Mass. Photograph by William Rittase.

Kitchen employes of the future: healthy, happy and well trained.

When more dietitians are employed, there will be more personal contact with patients and, after all, acceptance of your product is a selling proposition that can be done better by a member of the dietary staff than by someone less interested in the nutrition of the patient.

Another idea that seems to be fixed in the mind of the public and needs to be refuted is that institutions always buy food at low cost and, consequently, of low quality. Recently, when asked what new fruits were in, the man at the market replied, "Strawberries are in but hospitals are not buying them yet." Why shouldn't hospitals be the first to buy strawberries if they will tempt the sick patient even though the price is high?

There will be a reshuffling of dietitians for many young graduates have been rushed into war service or positions of responsibility and have not had the opportunity to serve as assistants and decide in what field they really belong.

The placement bureau of the American Dietetic Association will be geared to handle this change of employment when the situation arises but will need the help of the state associations and individual members of the profession. Now is the time to prepare for this important problem.

To summarize, in the crystal ball of the soothsayer I see for the future of the dietitian: increased appreciation of her services to the human race because of a better understanding of nutrition as a basic science; increased appreciation of her services by the organization in which she is employed and recognition of her as an important member of the staff, and increased participation by the dietitian in local, state and national affairs to the effect that good nutrition will be as strongly entrenched in the American life as the multiplication table.

I see the dietitian working in beautiful, streamlined kitchens, representing all types of food service. She is surrounded by clean, healthy, happy and well-trained employes. I see her in well-equipped research laboratories having sufficient funds to carry on long term nutrition investigations and I also see her in every school lunchroom throughout the land.

Finally, I see the dietitian leave her place of employment after a satisfactory day's work, go to a comfortable house or apartment to relax and engage in whatever interest comes next to her profession.

At her desk the following morning she is refreshed mentally and physically and will make a more wholesome contribution for having been released from institutional environment.

Another Vote for the Blue Cross

ROBERT N. BROUGH

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HOSPITALS have long been tolerant of criticism because they realize that it is inevitable in connection with the care of sick people. Public criticism to a certain extent is to be expected—and usually discounted. Internal criticism, or grouching within the ranks, may even be healthful as it sometimes leads to improved methods and procedures. Therefore, if persistent, it demands attention.

Last month four critcisms of radiologists concerning the practice of medicine by hospitals were analyzed and the conclusion was reached that present practices should be continued. Their fifth point is a vexed one, to the effect that Blue Cross or hospital service plans should exclude from their subscriber contracts any provision that would lead to the payment for medical services by such plans.

"Contract Medicine" Suspected

Physicians naturally feel that the close relationship between physicians and patients must be safeguarded in every way. Therefore, the introduction of "contract medicine" is looked upon with suspicion. For twelve or fifteen years this point has been argued back and forth here and there across the nation, with varying results and conclusions.

Long before nonprofit service plans became part of the economic picture, hospitals included certain medical services in their care of the sick, both under specific authority of law, as outlined in my article published in May and later under the following principles adopted by the board of trustees of the American Hospital Association in 1939:

"1. The primary obligation of the hospital is to provide and organize all the services necessary for the diagnosis, treatment and rehabilitation of the patient.

"2. Provision of medical services in hospitals is part of the responsibility of the hospital and is consistent with the rights, privileges and obligations of hospital staff physicians under their medical licensure. The performance of diagnostic and therapeutic procedures by staff members constitutes the practice of medicine *in* hospitals. It is not the practice of medicine *by* hospitals.

"3. The employment of a physician by a hospital is consistent with law and with professional ethics and does not imply that the hospital is engaged in the practice of medicine.

"4. The financial arrangement between a hospital and a physician is not a determining factor in the ethics or legality of medical practice in hospitals.

"5. No one basis of remuneration of a physician is applicable or suitable in all instances, nor should any such arrangement permit the hospital or the physician to exploit the other or the patient.

"6. The medical work of physicians is coordinated through existing hospital staff relationships, resulting in higher quality of medical care, greater efficiency in hospital service and lower cost to the patient.

"7. The responsibility for providing adequate and economical hospital care for the American people is not the responsibility of hospital trustees and administrators alone but calls also for the participation of hospital medical staffs and of the entire medical profession."

In harmony with these fundamentals, nonprofit hospitals and the Blue Cross plans have cooperated in an endeavor to offer to the public such services as are customarily rendered by hospitals. Certainly, nothing more has been included in service plan contracts, although in some instances something less has been listed in accordance with requests from the medical profession, based upon the theory of A.C.R.

It seems obvious that Blue Cross subscribers should be entitled to receive routine hospital services, just as other members of the public are when they are ill. There is no essential difference, on the one hand, between a patient going to a hospital at the direction of his personal physician and paying his bill when discharged, and, on the other hand, being admitted by his personal physician and paying the bill through a hospital service contract.

The introduction of the prepayment contract does not in any way alter the services rendered by the hospital, interfere with the private practice of medicine or handicap the specialist in charge of hospital laboratories or similar income-producing departments.

Before members of the medical profession question Blue Cross contracts including medical services, they should satisfactorily explain why it is right for hospitals to render x-ray and similar services to hundreds of thousands of private patients daily and at the same time why it is wrong for hospitals to render such services to patients who are subscribers to nonprofit hospitalization plans.

Blue Cross Will Suffer

This is not the whole aspect of the problem. If Blue Cross plans are prevented from offering broad contracts to the public, grave injury will be done them. The public will not be able to obtain what it wants and that to which it is entitled. Then it will be turned, indirectly at least, toward the Wagner-Murray-Dingell Bill offering so-called hospitalization and medical benefits under provisions that almost universally meet the condemnation of the medical profession. This is not the time for medical societies to take action that will inevitably tend to further such legislation.

That conclusion leads to the state-

Mr. Brough dissects the radiologists' quarrel with Blue Cross and concludes that logic is on the side of inclusive Blue Cross service as an aid to the physician as well as to the patient

ment that *the inclusion of medical services in Blue Cross contracts does not change in any way the accepted practice of medicine.* Blue Cross plans have not interfered with approved medical or hospital practices.

For fifty years or more unnumbered patients entered our American hospitals and received hospital and professional services exactly as contemplated by subscribers' contracts, to which exception has been taken. They paid for the services in routine fashion or did not pay, as the case might be. In turn, the physicians who rendered the medical services were compensated either directly or through financial arrangements with hospitals.

No Changes Have Been Made

The theory is now advanced that the Blue Cross plans introduce or contemplate some change or infringe upon the private practice of medicine. But it is difficult to see how that is so. Everything remains as it was except that through the Blue Cross funds the hospitals are surer of receiving payment than when they deal individually with countless patients.

As a corollary, physicians are more certain of being paid *adequately* by hospitals. This is particularly true because Blue Cross plans elevate many patients from ward to semiprivate or from semiprivate to private room accommodations and, in so doing, increase the revenue of special departments, such as x-ray and laboratories. In that revenue radiologists and pathologists participate. Therefore, they should favor and not hinder the growth of the nonprofit hospital service plans.

Experience demonstrates that medical services have been included in Blue Cross contracts in many of our states to the definite benefit of the medical profession. In New York State, New Jersey, California, Illinois, Connecticut, Ohio, Pennsylvania and many other areas, hospitalization contracts have served millions of subscribers, not to the detriment of the medical profession but to its benefit, because such contracts prepay hospital bills and leave a larger amount of money in the patients' pocketbooks to pay for the services of private physicians.

Aside from some theoretical observations that do not bear close analysis, there appears to be no good reason why the medical profession should object to the so-called inclusion of medical services in hospitalization contracts. No such service is provided by hospitals except under time-honored practices that have met with the approval of the medical profession for decades.

All that nonprofit hospitalization contracts do in essence is to prepay hospital bills from a common fund. Why should there be objection to "the magic of averages coming to the rescue of millions," as Winston Churchill so well puts it?

Blue Cross plans are in the unique position of benefiting the public, the medical profession and hospitals. Farsighted and cooperative action by the medical profession and the hospitals of the country, to further their growth, is clearly indicated. It is hardly within the realm of reason that, for the sake of an unproved and precarious theory, the medical profession insists that natural allies must break a partnership that has worked so well for decades.

It seems to be clear to anyone with an impartial mind that Blue Cross plans should not be debarred from paying for services which, at the direction of physicians, the public can obtain from hospitals when needed, but which if the new theory of radiologists is upheld will not be available through indirect Blue Cross payment. After all, the method by which bills are paid is not important, though we all agree that the payment of bills is an item that cannot be overlooked.

The inclusion of some medical services, particularly radiological, as a part of hospital service is a three-cornered arrangement that works well. With one or two minor safeguards it injures no one. Therefore, it is the policy of wisdom for hospitals, physicians and Blue Cross plans to "coordinate their efforts on the basis of complete mutual understanding and cooperation," so as to realize the following advantages offered by Blue Cross inclusive service:

1. Financial worries concerning illness are reduced because a major portion of the cost of illness is prepaid and eliminated, and in that way the recovery of patients is sometimes aided.
2. In some instances competition between the hospital and attending physicians for the patient's available cash is eliminated.
3. The patient-physician-hospital relationship is improved because no obstacle exists to full cooperation toward the patient's recovery.
4. Hospital charges tend to become more nearly uniform in comparable institutions because Blue Cross contracts with hospitals operate in that direction.
5. Hospital income is stabilized and guaranteed.
6. Patients with Blue Cross contracts more readily accept physicians' recommendations for hospital care as financial handicaps are removed and good health is not further endangered by unnecessary delay.

The Physician Benefits

All of these advantages directly or indirectly aid the physician in his task of healing the sick. They are not to be lightly disregarded. A service upon which the public has placed its stamp of approval should not be disrupted unless compelling reasons are presented, which so far have not been recorded. All the logic seems to be on the side of inclusive Blue Cross service. Hospitals should continue to provide it and should strive to make it more general, recognizing that they have made possible a genuine forward step in medicine.

Thus, a logical conclusion is reached: Blue Cross plans and nonprofit hospitals have joined hands in offering to the public services customarily rendered by hospitals. All concerned are benefited. Such cooperation does not change in any way the accepted practice of medicine. It merits support, not criticism.

The Pathologist Planned It This Way

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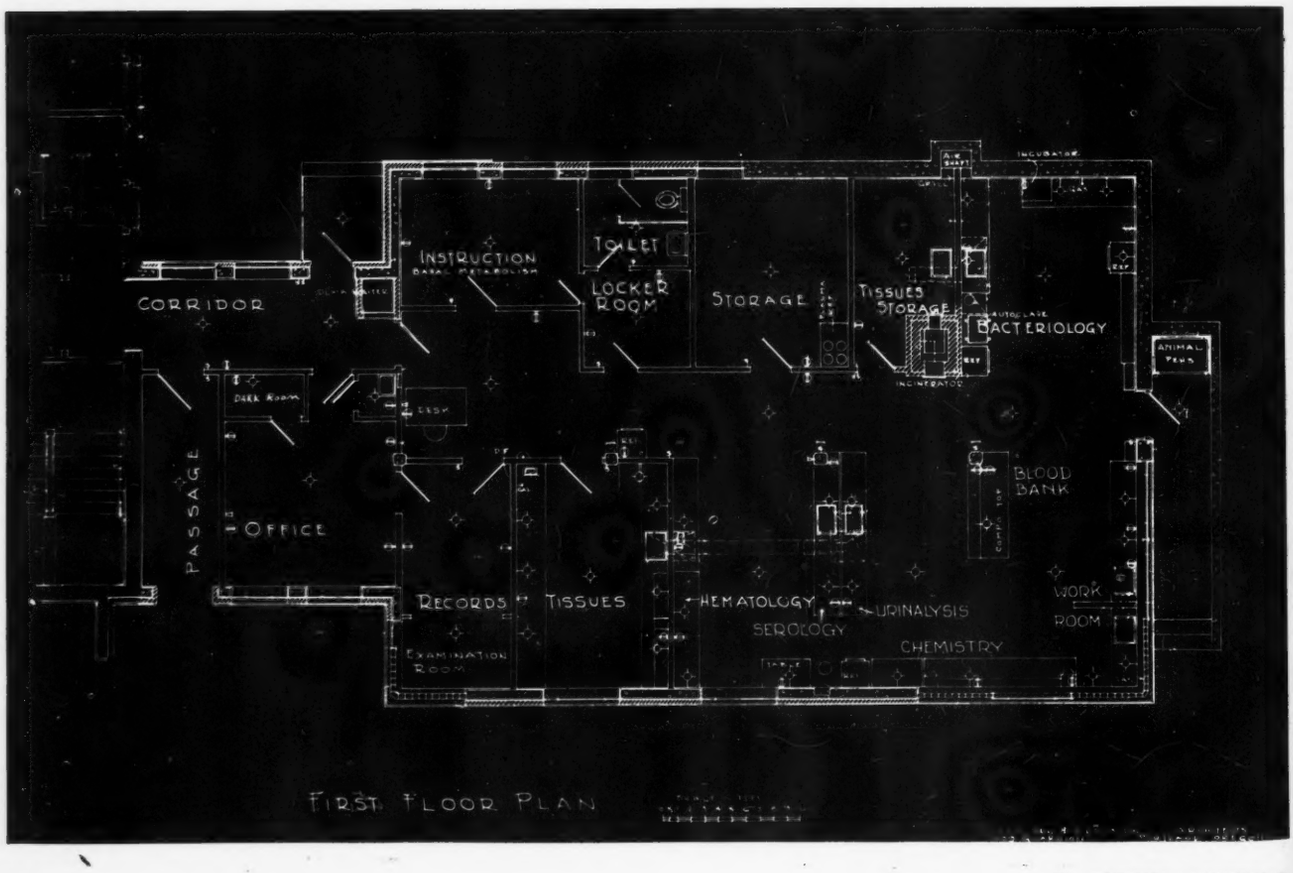
IN MANY hospitals the space allotted to the clinical and pathological laboratory is woefully inadequate, considering the volume of work done, the equipment necessary and the number of personnel required to perform the duties expected of a modern laboratory. Often, it seems that in the planning of a hospital little thought is given either to the location of the laboratory or to the floor space needed and, certainly, little to its needs as the hospital expands.

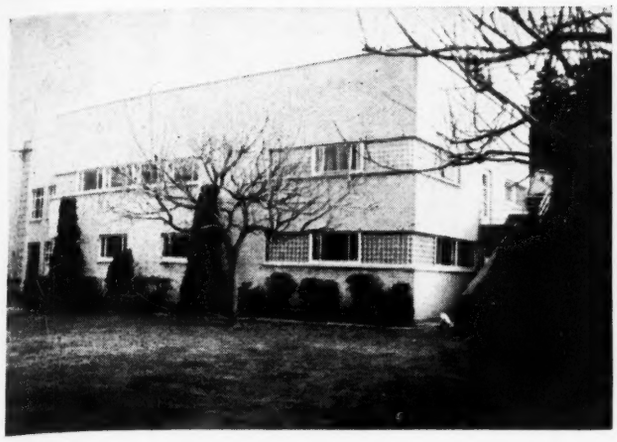
The result is that when the hospital grows the laboratory must either get along in its already cramped quarters, undergo major alteration or expand by the unsatisfactory method of taking over such adjacent rooms as may be available.

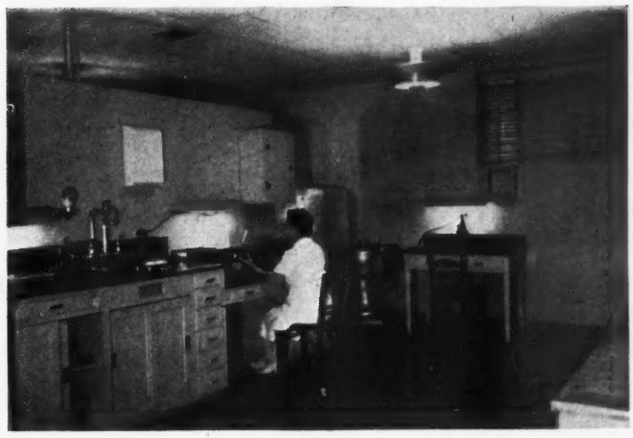
To have the opportunity of planning a laboratory from beginning to end is an uncommon experience in the lives of most pathologists. Such a pleasure fell to me when it became necessary to expand and to segregate the maternity division of Portland Sanitarium and Hospital, Portland, Ore., from the remainder of the departments. This was accomplished by adding a new wing to the existing L-shaped building of two stories. The additional wing has a physical connection with the main hospital on both floors by means of corridors. The entire second floor was assigned to obstetrics and the whole of the first floor became available to the laboratory.

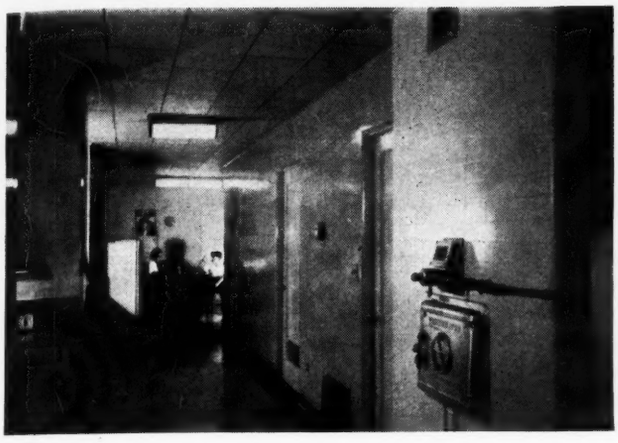
Admittedly, for a hospital with 157 beds, exclusive of bassinets, a laboratory with inside dimensions of 55 by 37½ feet, not including an office 13 by 13 feet for the director, is larger than is absolutely necessary for the present capacity of the institution. On the other hand, the hospital has expanded three times during the last twenty-five years and the management wisely took into account the possibility of future growth, Furthermore, the space available on the first floor was insufficient to accommodate any two divisions and it was decided to give all of it to the clinical laboratory. Thus, in future expansions of the institution it will not be necessary to consider relocation or alteration of this unit.

Under these fortuitous circumstances an ideal laboratory could be planned, From long experience with crowded quarters, I had the convic-









Top: West side and south end of the new wing housing the laboratory (first floor) and part of the maternity department (second floor). From this angle the glass brick, which was used on both corners, can be seen only at the corner nearest the camera. Below: Main corridor of the laboratory. At the rear of the photograph is shown the head technician's desk. In the lower right corner one of the doors opening into the incinerator may be seen.

Top: The serology section, depicting the staggered height of the work tables, half-partition separating this area from another diagnostic unit, individual hooded fluorescent bracket lamps, indirect ceiling light and the high position of the outside windows. Below: The bacteriology and parasitology division is segregated from all others. The sterilizer opens beneath the long hood, with a vent leading to an outside flue. Media storage cupboard is at the right.

tion that more accurate work may be expected of technicians who have sufficient room for segregation of apparatus and for real freedom of movement.

Sitting elbow-to-elbow or having to watch one's step in moving about in order to avoid breaking or spilling or trampling on another's toes is not conducive to good work or to tranquillity of temper on the part of technicians. This consideration led to the placing of the various diagnostic units from 7 to 8 feet apart and also leaving a wide central corridor through the center of the laboratory.

Ideally, certain parts of a laboratory should be fully partitioned rooms, provided with doors that can be closed. Certainly, surgical and necropsy tissues are best described and stored in rooms designed for the specific purpose, well ventilated and shut off from the gaze of those not concerned. Likewise, basal metabolic determinations can be carried out only in a quiet room.

Such procedures as stomach aspirations, bleeding for transfusion or plasma, sternal punctures and the occasional physical examinations made by the pathologist are best carried out in a real room. Finally, the director of the laboratory and the departmental secretary deserve the privacy of an office.

Still other features greatly appreciated by technicians are a locker room, private toilet and drinking fountain. The last mentioned was placed in the main corridor so as to be accessible to anyone entering the laboratory.

For most of the diagnostic procedures, individual units separated by half partitions facilitate ventilation and lighting, The plywood partitions were carried half way to the ceiling and between adjacent benches. The height is sufficient to provide for necessary shelving, to support apparatus and to discourage visiting across the table.

The space available was sufficient not only to provide ample room between tables but also to segregate the type of procedures. Thus, hematology, serology, urinalysis, chemistry, plasma pooling, bacteriology and a glassware cleaning unit were all given places, fully equipped for their purpose and eliminating interchange of apparatus or reagents.

The bacteriology unit is even more sharply isolated and is provided with a long hood for carrying off odors by means of an air shaft outside the building. The same vent serves the tissue storage room, aided by a slotted door leading to the main aisle.

Another feature, by no means

unique but often forgotten in the planning of a laboratory, relates to the height of work benches. Certain procedures requiring an appreciable time for performance are best done with the technician seated comfortably in a chair. Nothing is more tiring than having to climb up and down off a tall stool, particularly if it has no back.

Accordingly, the height of certain tables was varied to allow for sitting in a chair at some while others are intended for standing, In hematology, for example, half of the space, where staining is done, is convenient for standing, while counting is done at a lower table fitted for the height of a chair. The same arrangement was made for serology, bacteriology and for the stenographer in the tissue room.

To provide for quick and easy cleaning, all table tops likely to become wet or stained are made of stainless steel. All sinks are of the same material and are integral parts of the table covering, thus eliminating seams and hard-to-clean corners.

With few exceptions the faucets are provided with either long metal handles or a knee-control beneath the sink. The remainder of the tables are topped with a black, satin-finish composition material that does not show scratch marks and will retain its soft glossiness for many years.

A feature that I have not previously seen built into a laboratory is the incinerator. Located in one corner of the tissue storage room, it is provided with two doors, one inside the room so as to facilitate the discarding of tissues, the other on the main aisle. The burner also serves the maternity department on the floor above. A large gas jet, lighted once a day, is ordinarily sufficient to dispose of all malodorous material. After more than two years' occupancy of the laboratory, everyone is still enthusiastic about this feature.

The existing building and the available property made it impossible to construct the new wing so as to provide the laboratory with the always desirable north exposure. One entire side of the first floor and a part of one end as well rest against a cut into a high embankment; the north end connects with the main hospital. This leaves a west exposure for the length of the laboratory wing, together with a south face over a part of one end.

The problem of cutting off the undesirable afternoon rays of the sun was solved by locating the base of the windows on the west and south 6 feet above the floor level and fitting them with metal venetian blinds. Then, at each corner a generous amount of prismatic glass brick was employed. This not only allows plenty of diffused light to enter but greatly enhances the appearance of the building.

Temperature is controlled mainly by air conditioning, with auxiliary control accomplished by means of a single movable pane in each window.

Artificial lighting is of three types: (1) indirect, (2) direct overhead and (3) wall lights. Except for the bacteriology section, high-quality indirect daylight lights with built-in ultraviolet tubes were selected on account of their efficiency and the possibility that the actinic rays given off would aid in lowering the bacterial count of the rooms. The killing effect of this type of light on open cultures made it necessary to employ a fluorescent fixture in the bacteriology section.

A considerable number of single-tube vapor lights, each provided with a metal hood capable of being moved up or down by means of a ball-and-socket joint, are located above many of the work tables. This enables one to obtain brilliant light at any spot desired with a minimum consumption of current since each is provided with a pull cord switch. For the storerooms ordinary overhead incandescent fixtures suffice.

Another necessity of the modern laboratory is animal quarters. In our case the most desirable location proved to be immediately outside the building and at the blind end of a passageway leading to the back entrance. All-metal construction, individual cages, screen floors and sloping galvanized metal drains under each tier of cages, collecting troughs in front of the tiers and a common drain make possible not only segregation of animals but easy and thorough cleaning of the cages.

Highly desirable, too, is provision for departmental photography. A small darkroom, 6 by 3 feet, was partitioned off the director's office for this purpose. While small and perhaps not the best location, there seemed to be no other acceptable or available place in our plans.

Finally, a hospital laboratory need not be a drab looking place, shunned by all who are not forced to work there. Prismatic glass brick, venetian blinds, attractive asphalt block floor covering, tasteful and efficient lighting fixtures, fiber-board ceiling of soft or neutral color and a restful tone of green paint for the walls give the laboratory a quiet atmosphere and an attractiveness that are conducive to a pleasant state of mind on the part of its personnel.

The responsibilities of the laboratory are many and varied; the work is exacting; accurate results are expected. Surely, the extra initial cost of providing adequate space in the first instance and then applying those touches that make for comfort and contentment are likely to pay dividends in the form of a lessened turnover of technicians and better work on their part.

Presenting—the Budget
A Plan for the Future

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THE first step in planning the hospital's budget is the preparation of an estimate of income for the approaching fiscal year. The figures for the current and two preceding years should be carefully analyzed in order to disclose either favorable or adverse trends. Now, income is not easy to forecast and several factors must be taken into consideration. What does the ensuing year hold in store for the community? Will there be boom crops or are crops likely to be far below normal? If the hospital is located in an industrial area are any new plants to be placed in operation or will any of the present operating concerns be likely to close? Will there be any possibility of additional hospital facilities becoming available in the locality? What is the outlook for a labor shortage or a serious unemployment situation?

Don't Depend on Donations

If endowment income is counted upon heavily for the coming year, the securities field should be subjected to careful study by the banker member of the governing board. Unless the hospital has a group of loyal supporters who have consistently come forward with donations year after year, this source of income should not be depended upon too heavily since an unfavorable economic situation brings with it a curtailment of such gifts.

As is the case in estimating the income items the forecasting of expense will likewise require a review and an analysis of the experience of the last two or three years. This will involve a great deal more detail than was encountered in the income study and it is best accomplished by individual departments.

Each department head should be given the opportunity to discuss with the administrator plans for the ensuing year and to make requests for whatever additions to equipment, repairs and replacements, increases in personnel and alterations she feels are indicated. Unless heads of departments are granted this privilege and are made to feel that they have participated in establishing the allocation for their divisions for the coming year they cannot be expected to show much interest in complying with the budget.

They have the right to know each month how closely they are adhering to their appropriation and no transfer of funds affecting their department should be made without their prior knowledge.

On the whole, expense items consist of two main groups: (1) salaries and (2) supplies and expense. The supplies and expense can, in turn, be separated into two subgroups, consumable supplies and recurring expenses in the one, and nonrecurring items of expense, purchases of equipment and special maintenance items in the other.

Salary estimates are probably the most important as it is usually the salary budget that must be adjusted when available funds are found to be insufficient to meet the needs of the hospital. At the University of Chicago Clinics each nonacademic position has been classified on the basis of duties and a salary scale has been established that calls for definite increases at stated intervals, if merited. This enables the accounting office to furnish the administrator with lists of all the employes in each department, their present salaries and the amount necessary to cover their annual salaries, including scheduled increases, for the following year.

Such a policy renders accurate budgeting possible and makes an upward revision necessary only when a general increase is granted to the whole department. Barring this contingency there will usually be an unexpended balance at the end of the year inasmuch as all replacements of employes who resign will come in at the lowest step in the classification while those who leave are often in one of the higher steps.

This Group Hard to Plan for

The subgroup of supplies and expense consisting of consumable and recurring items, such as food, medical and surgical supplies and linens, can usually be fairly accurately estimated on the analyses of past years but the advice of the purchasing agent should also be sought regarding market trends.

Should the hospital not have the services of a purchasing agent the administrator would do well to seek the counsel of a fellow administrator whose hospital does have a purchasing agent or should discuss the future situation with his suppliers.

Other recurring items of expense, such as telephone, heat, electricity, care of equipment, alterations, decorating and repairs, can be readily estimated on past experience and should offer no particular difficulty.

The subgroup made up of nonrecurring expenses, such as the purchase of new equipment or the replacement of old and alterations in the physical plant, is difficult to plan for these days and depends largely on the need for and the availability of material. The question of a budgetary item covering the depreciation of various pieces of equipment and providing for their replacement has long been a moot point and will probably never be settled to the satisfaction of every administrator.

We may as well be honest with ourselves and face the fact that all equipment eventually wears out and must be replaced. Since this is the case why should we not make pro-

From a paper presented at the Wisconsin Hospital Association, January 1944.

vision for such replacement as painlessly as possible? Such a provision is not so essential in the replacement of many items whose cost is comparatively small but the purchase of heavy dietary equipment or new x-ray units is quite another matter.

With the certainty that such large expenditures must be made within a known period of time, why should we not set aside a prorated amount each month rather than have the blow strike all at once, possibly in a year when it would be utterly impossible to provide the necessary funds? After all, a budget is a plan for the future and even though it covers but one year's operation this does not preclude making provision for some years ahead.

After all expense items have been thoroughly studied and decisions made, the figures are compiled with the hope that the total will be less than, and most certainly will not exceed, the estimated income. Happy is the administrator who finds that his careful prognostications have resulted in a balanced budget. If the income figures are in excess of the estimated expense the difference is set up as a contingency item in the expense budget to cover unforeseen items that almost invariably arise.

On the other hand, should the expense estimate be in excess of the hoped for income it will be necessary to restudy the former with a view to eliminating certain items and reducing others to a point that will bring the two totals into balance. There is always the unpleasant possibility that the two amounts cannot be made to coincide even though every possible item of expense has been reduced to a minimum. In this event a balancing amount to be underwritten from a reserve, special gift or some other source must be inserted in the income estimate.

Administrator Must Explain

The budget is now ready for submission to the board for its approval and the administrator may have a rather warm session in store for him. As was the case with the individual department heads he must be prepared to explain every single item if necessary and to offer valid reasons for any points that may be questioned.

It is the function of the board to see the hospital through a successful year and the trustees are duty bound to cast a critical and inquiring eye over the budget before they assume the responsibility that its adoption will entail. Once it is adopted it grants to the administrator the board's authority to carry on.

The next step is the control of expenditures under the budget and is extremely important. In a large institution the system of control should be so carefully worked out that the administrator need not concern himself with routine expenditures as the accountant will be able to detect any that may be unauthorized and bring them to his attention for special consideration.

In our own organization this is accomplished by a system of commitments charged against the budget in memorandum form. In the case of salaries, the accountant calculates the annual salaries of all the employes in a department, taking care that the total commitment does not exceed the budget appropriation. A similar plan is used in apportioning the appropriation to cover the various expenses by using blanket requisitions for recurring items of a certain type and special requisitions for equipment purchases or unusual expenditures.

The term requisition as used here must not be confused with an order for supplies from a storeroom but is a request to set aside a definite portion of the budget appropriation for a specific purpose. Requisitions are drawn at the beginning of the fiscal year and must be approved by the administrator before becoming effective. They can be reduced or increased from time to time if the need arises and funds permit.

Special requisitions for nonrecurring items of expense are handled in the same way except that they are drawn for one specific purchase whereas blanket requisitions cover all the purchases of a similar nature made through one source for the year. It is the duty of the accountant to keep the total of the requisitions within the budget appropriation and to refer to the administrator any requisition for which funds are not available.

With his multiple duties it is impossible for the administrator of a large hospital to keep track of all expenditures but since all transactions must go through the accounting office the chief accountant can keep him informed about the things he should know. In the small hospital it is likely that the administrator would approve every requisition and would therefore be in a position to know the situation from day to day.

All requisitions, if not actually originated by the department head, should at least pass through her hands for approval. She must, and no doubt will, insist on this system if she is expected to assume the responsibility for the state of the departmental budget. It would, of course, be foolish to expect the director of nurses to make up the requisitions for drugs and dressings for the various nursing divisions but they should be routed through the central nursing office for her approval before going to the pharmacy or stores clerk.

Inventories Should Be Watched

Proper control must be exercised in the matter of inventories as overstocking of supplies is dangerous and may work a hardship under the budget system. The purchasing agent is expected to be budget-conscious and to act accordingly but he should not be restricted and must be allowed to use his own best judgment in the matter of quantities on hand.

The monthly financial statement from the accounting office should show the income by departments for the current month and the year to date, the corresponding month and previous year to date and the prorated budgeted income for the same periods, in parallel columns. Likewise, all the various departmental and general expense items should be presented in the same way. This enables the administrator to analyze the situation and readily to make comparisons between the current and previous months and years.

The department heads need not and, as a matter of fact, should not receive the complete periodic financial statement but they can expect to be furnished with a monthly statement of the condition of their departmental budget. Such a report stimulates them, keeps them budget-conscious and makes them feel more of a sense of responsibility toward the over-all operation.

One of the chief objections to a budget system in the minds of many administrators is its inflexibility. This can be readily overcome by the

board in granting the administrator the right to transfer funds from one budget appropriation to another as the need arises. In granting this broad authority it is understood that such transfers will not result in any alteration of the total budget as originally approved.

Should conditions change to such an extent as to affect the original income or expense estimates a complete budget revision will be required, such a revision being, in effect, the substitution of a new budget for the old and requiring approval by the governing board.

Budget systems may be made to fit the problems of any hospital, large or small, and may include budgeting of quantities as well as dollar values. To the administrator of the small hospital the formal budget may seem unnecessary and burdensome but regardless of the extent to which it is developed the systematic planning for operations in advance and the checking of the actual experience with the preconceived plan are bound to be of value.

We could have no more propitious time to institute such a procedure than the present offers. We have all been impressed by the fact that we have, somewhat to our surprise we must admit, been able to get along without many things formerly thought essential.

Such a situation is certain to make us economy-minded and before we get out of the habit we ought to make an attempt to maintain this attitude in the future by placing our activities on a planned-in-advance basis.

Why the patient *feels better*

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State of Wisconsin General Hospital, Madison, Wis.

"I FEEL so much better, Doctor," exclaims the patient in Room 215 who had entered the hospital the night before, August 31, suffering from severe bronchial asthma. He had had almost constant dyspnea and wheezing for about two weeks, relieved for short periods by epinephrine given hypodermically. Similar episodes had occurred about August 15 for several years.

It was assumed on admittance that the patient had pollen asthma and he was placed in one of the "pollen-free" rooms. Suitable immediate medication for relief of symptoms was given and he had had several hours of refreshing sleep, followed by a good breakfast and he was lying comfortably in bed. Examination of the chest revealed only an occasional wheeze.

He was indeed "better." Why? The probabilities were because of his environment. Early in August the room to which he was assigned had been thoroughly cleaned and dusted and a pollen filter had been installed in the window. The doors and windows were closed.

A few days before the date when a large amount of ragweed pollen was expected to appear in the air, the fan in the filter was turned on. A large amount of outside air was drawn into the room, the excess escaping through the cracks around the doors and windows. Dust particles and pollen grains do not pass through the filter. Such materials in the air of the room are gradually forced out by the rush of new air and in two or three days the room is practically free from dust and pollen granules.

For about fifteen years mechanical filters have been placed in certain rooms of the student infirmary at the University of Wisconsin during the ragweed pollen season. University students and patients from Wisconsin General Hospital suffering from incapacitating hay fever and asthma are admitted to these rooms for periods of hours, days or weeks with usually beneficial results. Various types of filters have been used, from the old-fashioned cumbersome machines designed years ago (they still are in use) to the modern comparatively small one placed in the window, resting on the sill. The general principle of all is similar—a fan draws outside air through a filter of wool, cotton, paper or, more recently, the newer cellulose materials, leaving pollen and dust grains on the outside.

For many years accurate pollen counts were made daily from slides exposed outside the windows, both in open-windowed rooms immediately adjacent to the filtered ones and in the latter, with gratifying results. Over long periods the counts in the unfiltered rooms showed from 20 to 30 per cent as much pollen as outdoors. In the filtered rooms often no pollen grains were observed and the counts in these rooms never were higher than 0.35 per cent of that for the outside air. We found the simple inexpensive machines as efficient in filtering the air as the more expensive types. Vaughn and Cooley (1933) reported similarly good results as have many other observers.

There are disadvantages to the patient in the air-conditioned room, usually not sufficient to outweigh the marked relief obtained from symptoms. The noise made by the fans especially in the older machines is annoying; the outside air drawn in may be too hot, too cold and often too moist. Usually there is insufficient circulation in the room and additional fans within the room are necessary. The expensive machines that contain heating and cooling units under thermostatic control in addition to the filter are almost ideal but the cost is too high for the average individual. It is likely that within a few years such machines can be obtained at moderate prices.

Often it is found that pollen sufferers need only to sleep in the filtered room to obtain relief the following day. Certain new hospitals throughout the country have erected permanent air-conditioned rooms for the benefit of their allergic patients.

Probably these notable advances in the care of such unfortunate patients will be adopted by other institutions whenever possible.

We Fight Tornadoes, Too

H. B. MORGAN, M.D.

Superintendent, Greenwood Hospital, Greenwood, S. C.

A tornado which on April 16 cut a 100 mile path of destruction across northeast Georgia and western South Carolina resulted in the death of some 38 persons and injured more than 500. It inflicted considerable damage as well to property including hospitals, which in addition to caring for their regular patients were called upon to provide for the victims of the disaster.

Churches were transformed into emergency hospitals, armories became temporary quarters for the injured, electricity was cut off for many hours, wreckage blocked the roads—yet despite these and other grave obstacles rescue work went forward successfully.

Much of the fury of the storm centered upon Greenwood, S. C., where the 83 bed Greenwood Hospital, including 15 bassinets, without the benefit of a complete roof and with two thirds of its facilities destroyed, carried on valiantly without any harm to patients and with but two minor casualties.—ED.

SATURDAY night, April 15, everything was as usual. The census was 49. Without warning the storm broke. As unexpectedly we found ourselves minus seven beds in the downstairs west wing. Fortunately, no patients were there at the time. Four children in the west wing and five patients in the ward were saved only by some miracle.

The obstetrical ward upstairs housing 14 beds was rendered completely useless and the four babies in the nursery came through unharmed despite the fact that the door to the room was blown off, whipped back through the nursery and extruded through the window. It so happened that none of the babies was in a direct line with the door. At least 13 private rooms were damaged to the point of being useless. These conditions notwithstanding, all patients were provided for between the hours of 1:15 and 6 o'clock Sunday morning. During and immediately following the tornado 12 casualties were admitted.

What the Tornado Left Behind

I would like to try to visualize for you the picture that confronted me when I arrived at the scene of the disaster. Emergency casualties were being put in the hallways, in the basement, in the reception room, in the x-ray department, anywhere, in fact, they could be considered safe.

Under such handicaps doctors and nurses and the complete hospital personnel were carrying on. Lights in the building were out and the local electrician with a few co-workers had emergency lights going all over the building within an hour and a half.

We found our training in emergency blackouts under theoretical bombing conditions extremely beneficial. Dr. W. A. Simpson in charge of the medical unit and emergency station was on the job and was soon receiving assistance from every doctor in the county and city who knew of our trouble. All the nurses in the vicinity appeared to help us.

Women volunteers of the Red Cross came in and served sandwiches and coffee, taking over the kitchen department and handling it like veterans. Breakfast even was served the following morning almost at the usual time. The biggest obstacle was that our workshop was two thirds destroyed.

All of the local organizations in the city responded at once to our call, including the fire department, electricians, telephone operators, plumbers and other maintenance men. Doctors and nurses from adjoining towns reported and officials from the Greenville Air Base appeared with an emergency ambulance and fully equipped personnel. We also had volunteers from the Coronacre Air Base.

The mayor of the city offered every facility to help clean up after the extensive damage which had occurred so suddenly. Boy Scouts rallied to our aid and were constantly on the job. The Western Union office and Radio Station SCRS of Greenwood handled the news of the disaster. We also had State Home Guard units and the American Legion on the job constantly. Trucks from textile plants, transportation and other companies were at our disposal, constantly removing some of the equipment from the building.

By 10 o'clock Sunday morning we had set up an emergency station in the local armory building to which we evacuated as quickly as possible minor casualties and convalescent patients from the hospital. Monday, the following day, we had set up an obstetrical clinic in the U.S.O. building in the center of town, which proved satisfactory for emergency deliveries. In consequence, we have had little trouble taking care of the obstetrical work.

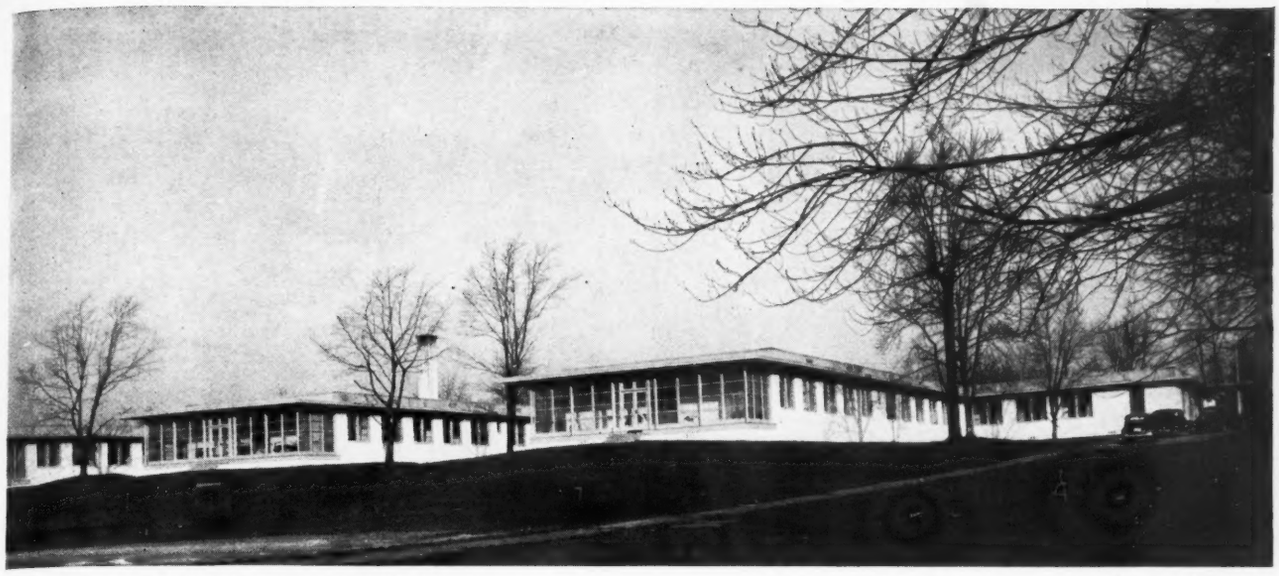
In three days we had reduced our hospital patients in the back part of the building, the only wing that was not damaged, to 18 patients and we have carried on our emergency hospital work with this bed capacity. In one of the larger rooms having water and bath facilities, we set up an emergency surgery.

One of the most significant aspects of the emergency was the attitude of the board of trustees. The chairman, John Sloan of Greenwood, was on the job before daybreak. By ten o'clock Sunday morning a meeting of the board had been called at which time one member made the announcement that, when materials and labor were available, he was prepared to build a 100 bed, modern hospital and give it to the town.

"It's an Ill Wind"

By this time, having realized that there had been no deaths and few casualties, we recognized that it was after all an ill wind that did not blow some good.

Of course, I hope that such a disaster never happens again to any hospital regardless of its size. Within three days we had a complete temporary roof on the whole hospital and within a week the nurses' home was also covered. What we are still amazed at is that no member of the hospital staff was hurt seriously. We had only two casualties one of which was discharged from the hospital later in the afternoon of April 16 and the other on April 18.



SUBURBAN HOSPITAL, BETHESDA, MD.

Federal Works Agency Photographs

Built by Popular Request

V. L. ELLICOTT, M.D., Dr. P.H.
County Health Officer
Rockville, Md.

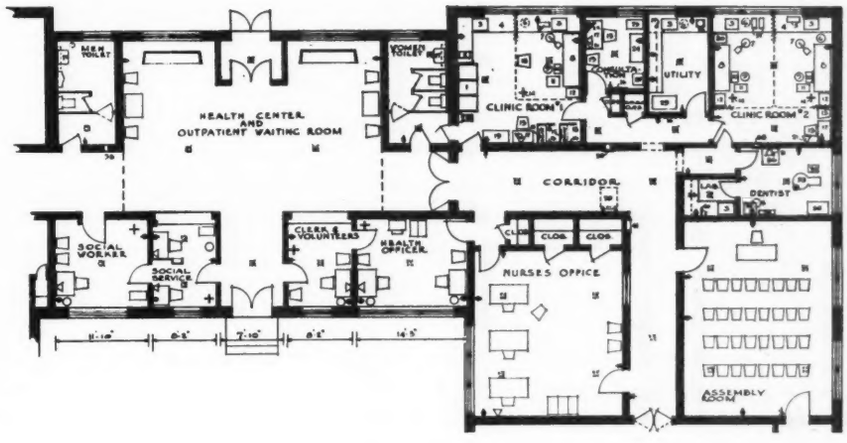
FAULKNER and KINGSBURY
Architects, Washington, D. C.

FEW rural communities have so far provided a hospital service that, in the true sense of the word, can be termed correlated with the public health program. Yet a study of the health needs in almost any county would show that lack of hospital service represents a serious obstacle in the health program. The doctors' examinations of school children, for example, reveal many diseased tonsils, but public health nurses report that they can arrange hospital operations for only a small number.

The health needs associated with hospital care have not yet been met in Montgomery County, Maryland, but a determined influential citizen body has already made progress in that direction.

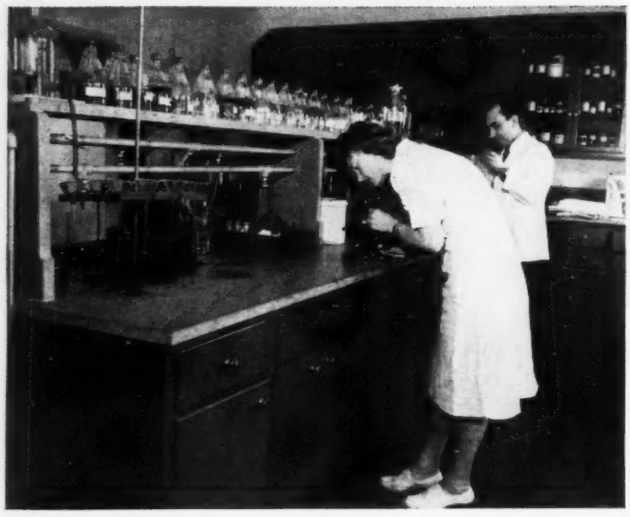
Suburban Hospital, Bethesda, Md.,* the first Lanham Act hospital to be constructed on the combined hospital and health center plan, was finished Dec. 1, 1943. It is unique in that it was initiated by an organization which had had eight years of previous interest in the health program.

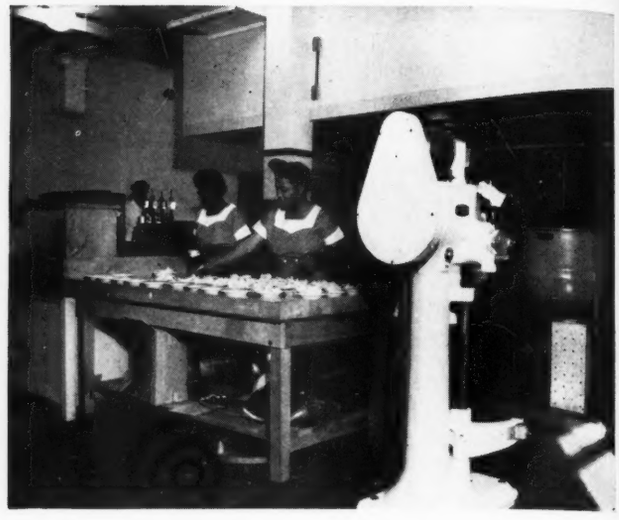
*Built in collaboration with Hospital Facilities Section, U.S.P.H.S., and Emergency Operations Section, Public Buildings Administration, F.W.A.



LIST OF EQUIPMENT

1. Baby dressing tables
2. Baby scales
3. Sink
4. Counter (drawers and cupboards under)
5. Instrument sterilizer
6. Waste can
7. Lamp
8. Examination table
9. Stool
10. Footstool
11. Instrument table
12. Instrument cabinet
13. Chair
14. Costumer
15. Mirror
16. Hookstrip
17. Desk
18. Dressing booths
19. Demonstration table
20. Adult scales
21. Phone jack
22. X-ray viewer
23. File cabinet
24. Baby examination table
25. Lavatory
26. Counter (cabinets over, cupboards under)
27. Bunsen burner
28. Hot plate (open under)
29. Pressure sterilizer
30. Pneumothorax
31. Microscopes
32. Dental unit
33. Dental chair
34. Instrument sterilizer on stand
35. Supply cabinet
36. Table
37. Lavatory (shelf and mirror over)
38. Fire extinguisher cabinet
39. Ladder and access door to roof
40. Air and gas supply
41. Electric panel





Left: The laboratory makes an important contribution to the health of the citizens of western Montgomery County. Right: Preparing salads for in-patients.

This group, the Bethesda-Chevy Chase Public Health Lay Committee, a subsidiary of the Montgomery County Public Health Lay Council, started a hospital movement by calling a mass meeting of leading citizens on April 10, 1942.

The Suburban Hospital Association which formed as a result of this meeting was thus founded on a background of public health interest. From the beginning this group was determined that the hospital facilities should be utilized to the maximum in solving the community's health needs.

One important problem that the hospital has already taken care of is that of health center space. The northwest corner of the hospital building provides an ideal headquarters for the health activities of the 30,000 citizens in the western suburban area of the county. The center is operated by the county health department under a lease from the hospital. A small part of its rent is paid by the public health lay committee, the county paying the remainder. Thus, the health center operating cost does not raise the hospital overhead.

When the hospital opened, the health center was moved from its previous unsuitable space in a commercial building. At this time the following clinics were being held: a weekly venereal disease clinic, a monthly maternal-child hygiene clinic, a monthly chest clinic and a monthly dental clinic. Plans call for a gradual increase in the number and frequency of the clinics.

The hospital is making a point of accepting those patients whose bed care is of public health importance. Inasmuch as most of these patients come from low-income families, the hospital has wisely put into operation a plan, through the Community Chest and official agencies, of employing a hospital social worker as an admitting officer. This worker also gives part of her time in similar service at Montgomery County General Hospital, a privately operated nonprofit institution in the rural part of the county. Thus, Suburban Hospital may take credit for initiating a much improved hospital plan for the county as a whole.

As county health officer, I feel that under this new plan the hospitalization of complicated maternity patients referred from the county's nine maternal-child hygiene clinics has in itself constituted the biggest advance of the county's child hygiene program in the last five years.

It is too soon to predict the value of the hospital in other ways, including communicable disease hospitalization. So far, however, one case of scarlet fever and one of meningitis have received hospital care. In the course of time we hope to be able to arrange for malaria treatment, for neurosyphilis and, possibly, for penicillin treatments for primary and secondary syphilis patients in localities remote from clinics; also for occasional care of tuberculous patients whose state residence is too short for acceptance in state sanatoriums.

The health department's local maternity clinics and the hospital's outpatient obstetrical clinics will be operated as a combined clinic once a week. The dental room, located in the health center space, will be used part of the time by the county health department dentist for service to school children and patients attending the health department clinics and part of the time, it is hoped, by local practicing dentists in the form of a hospital out-patient service.

The hospital clinic committee is beginning now to operate a general medical clinic. This will be a great help to health department clinics throughout the county because patients with disorders other than those covered in health department services can be referred for diagnosis and treatment. A venereal disease patient with neurosyphilis, for example, may need tryparsamide treatment but cannot with safety receive this without a preliminary ophthalmological examination, including a mapping of the eye grounds.

The hospital authorities realize that the health of the citizens depends, in no small part, on the opportunities afforded the general practitioners to keep abreast of the times in newer medical knowledge. Outpatient services of hospitals are rich in such opportunities. The clinic committee wishes them to be available to all physicians of the county. The hospital's objective is therefore not limited to the maintenance of high professional standards within the hospital itself. It hopes to be of influence in maintaining similar standards in the medical practice of the community.

Mayor La Guardia steps forward with
A Plan for Medical Care

LOUIS H. PINK
President
Associated Hospital Service of New York
and Member of the Mayor's Committee

THE health plan proposed by Mayor Fiorello H. La Guardia which has aroused such great interest in New York City is, of course, not yet a definite project but rather a suggestion of what the mayor thinks a health plan should be. Some of the details will undoubtedly arouse discussion and controversy throughout the country, particularly among medical men.

Mayor La Guardia's plan will cover normal as well as catastrophic illness; that is to say, it will include: general practitioner at home, office or hospital; specialist services for all treatments and necessary consultations; diagnostic, x-ray and laboratory services; major and minor surgery; maternity care—prenatal and postnatal care for mother and child; child care; preventive care; visiting nurse service, and all other hospital services.

It Can Succeed

Two outstanding features give the plan real possibility of success, *i.e.* the open panel system with free choice of physician and the mayor's offer to have the city pay half the cost of a complete medical program for city employes.

There are no accurate actuarial data with regard to the cost of this plan, which includes not only coverage for catastrophic illness but home and office care. Most of the medical prepayment plans cover only surgery and illness requiring hospital care.

The medical profession is called upon to underwrite the plan just as the hospitals underwrite the Blue Cross plans, and there is no certainty as to what charge must be made to cover the services rendered. An intelligent guess based upon the various experiments throughout this country and Canada is about all that can be given. Such a plan, including hospitalization, would probably cost $40 annually for an individual, or $90 for a family.

The difficulty with a plan as broad as the mayor's is not only that there is little actuarial experience on which to determine the proper cost, but the danger of abuse is considerable. Only eternal vigilance by the medical profession can control this. A workable method for control must be evolved. But if voluntary effort is to reach the people and do a real job, preventive and diagnostic service, home and office care and, eventually, nursing and dentistry must be included with medical care and hospitalization. The mayor's plan at least presents a worth-while challenge to the medical profession.

The power behind it is the 150,000 city employes and their families. It will probably cost the city approximately $8,000,000 to pay half the expense for the employes and their dependents. If only 100,000 employes join, they with their dependents will be a nucleus of some 300,000 subscribers. It is hoped that private employers will follow the city's example.

In the beginning the plan will probably appeal only to the larger employers. It will be much more difficult to get a large membership through employer-interest in New York, where there is little big industry, than in cities, such as Detroit and Cleveland, where a larger portion of the employes work for a few firms.

Two controversial features of the plan are income ceiling and control. Mayor La Guardia's plan suggests a ceiling of $5000 per family, which is considerably higher than any suggested by the medical profession. The medical profession fears chiseling by people of means, who would join the plan merely to get complete service, when they could afford to pay prevailing medical rates. But as a practical matter if there is large volume, the ceiling is not as important as it seems.

When large groups are enrolled, such as all city employes, it would pay the plan to accept them without much regard to income ceilings, excluding only the more highly paid officials. Perhaps a fair compromise can be made on income ceilings; in any event, from a business standpoint the ceiling should vary with the size and the character of the groups enrolled.

The second controversial point is control. The mayor suggests a lay board to control business, with the medical board having control over all medical matters, patterned after the dual control in voluntary hospitals and universities. Undoubtedly, many physicians will feel that, if they are to co-insure and save the plan from loss as is proposed, they should have a majority on the board of directors.

No plan can succeed if the doctors are not paid fair fees and actually receive what they are promised. Whether the financial control is in the hands of laymen or medical organizations, there must be reasonable certainty of collecting the fees or the plan will fail from the start.

Blue Cross May Participate

It is probable that Associated Hospital Service will be expected to provide the hospitalization and, although no definite conclusion has as yet been reached, it may be asked to use its organization as sales agent for the plan. This arrangement has proved of value in Michigan, Massachusetts and several other localities and a similar relationship now exists between Associated Hospital Service and Community Medical Care, Inc.

Physicians have never had a reputation for successful business operations. They are professional, not business, men. It is possible that other things being to their liking, they will be content with complete

control over all medical standards and affairs, leaving to others the business headaches, which will be many.

One important point that has aroused opposition is a suggestion by the mayor that the "total charge will be approximately 4 per cent of the employe's wages." This has been construed to mean that the charge to each subscriber will be based upon his salary and that a definite percentage of salary will be deducted, no matter whether the subscriber is married or single or how many children he has. This is customary in the case of social security taxes imposed by government but is not practical in selling insurance or any other commodity upon a voluntary basis. It is discriminatory and is probably contrary to the insurance law of the state.

It is not reasonable to expect that some people will pay a great deal more than others for the same commodity, unless compelled to do it. The mayor's language should not be construed to mean that he is committed to this method of payment. The statement that the total charge will be approximately 4 per cent was meant to indicate the probable cost of complete medical services.

In announcing his plan Mr. La Guardia indicated that he strongly favored the Wagner-Murray-Dingell Bill and regarded this plan merely as an expedient until government is ready to assume control. This has scared a great many people and may make it more difficult to obtain the cooperation of the medical associations and others who believe in voluntary effort.

However, in a community undertaking of this kind there is no logical reason why those who are for and those who are against the Wagner-Murray-Dingell Bill may not participate and try to fulfill a community need. Those opposed can well argue that if the mayor's plan, which is to be effected through a private nonprofit organization, can succeed there is much less need for the government compulsion and control indicated in the Wagner-Murray-Dingell Bill.

It probably was not stated clearly enough that the mayor's plan is not a city plan as such. It is to be run by a body of citizens through a nonprofit organization and the medical end of it is to be controlled by a medical board. The city as such will have no direct control.

The mayor's plan cannot succeed without the full cooperation of the medical profession. Out of his suggestion there should come conferences among the mayor's advisers, the medical organizations and the three existing medical plans in the New York area. It is the hope of all interested in a practical and forward-looking plan that unity can be achieved and that there will be but one medical plan in the community. Medical Expense Indemnity and Community Medical Care, the latter affiliated with Associated Hospital Service, have just completed the legal requirements for a merger in order that they may do more effective work. This is a step forward.

The merged organizations have not yet determined upon the coverage to be offered but it is generally accepted that, if an agreement is not reached with the mayor, a modestly priced service plan will be offered for catastrophic illness and that in the near future broader coverage, providing preventive features and also home and office care, will be made available. The relationship between Associated Hospital Service and Community Medical Care will be continued with the merged corporation, known as United Medical Care.

If it proves impossible to get the medical profession and the existing medical plans to agree with the mayor on a united effort, it is probable that the medical corporation that the mayor plans to organize will attempt to work out a plan with a limited panel of physicians, on a salary basis. There are undoubtedly some important differences between what the medical profession desires and what the mayor and his advisers want, but a fair compromise that will permit united effort and the pooling of all resources should be sought. This will make possible the most significant experiment yet undertaken in medical prepayment insurance.

Subscribers Have a Vote

R. F. CAHALANE
Executive Director
Massachusetts Hospital Service, Inc., Boston

WHEN the original by-laws of the Massachusetts hospital service plan were revised, an attempt was made to give subscribing groups a voice in the election of members to the board of directors. The Associated Industries of Massachusetts, which represents industry at large, was allotted two votes, and the Boston Council of Social Agencies was allotted two votes; the Massachusetts Medical Society and the Massachusetts Hospital Association were allotted 25 votes each.

Each year 23 subscribing groups are elected, each having one vote. They are elected for two years. Any subscribing group must have been enrolled for at least six months before being eligible to send a representative to the annual meeting. No person is selected by the voting members to represent a group; the group itself is privileged to make this choice. The person selected is usually the executive who is considered as the group leader. In some instances, where there is an employes' organization, a representative of the group is appointed.

At the annual meeting an opportunity is given the voting members to hear reports of officers and to participate in discussions of any questions that may be raised by the officers or from the floor.

It is a requirement that a majority of the board members must be administrators or trustees of member hospitals. It has been the practice to have a number of doctors of medicine on the board properly to represent the interests of the medical profession. Many hospital trustees serve both the interests of hospitals and the subscribing public and, of course, many board members have no hospital affiliation and primarily represent the interests of the subscribers.

In selecting nominees for voting members, every effort has been made to give representation to the various sections of our commonwealth.

Learn to *Work Well With Employes*

In these times, for maximum production, machines and materials are not enough. We need the individual skills and the maximum cooperation of every man and woman who are in any form of work that is essential to the war, as hospitals assuredly are.

You know how important it is not to have any lost production because of misunderstandings on the job or because people do not realize the vital part they have in the war effort or because someone is slowed down on his job by things that happened off the job.

Experienced supervisors who have demonstrated their ability to "work well with people" have developed a special skill. You can acquire this skill. By making use of it, you can be surer of meeting your production requirements.

This is the time; and the place is right where you are!

C. R. Dooley,
Director, Training Within Industry Service.

DOES anyone in your department ever refuse to do some particular job? Or, maybe, even quit his job? Do you have any people who are discouraged or who make other people dissatisfied?

Are there any changes being made in your organization—in how you work, in what you do, in the people you work with?

Does everyone come to work regularly, or are you ever held up by absenteeism? And do you ever find you are by-passed by people who go over your head to your own boss?

All job relations problems do not come up at once, but they do occur, and management does hold department heads and supervisors responsible for handling such problems.

The supervisor today needs a high degree of skill to handle his own problems. But, as part of the skill, first of all, he needs a strong foundation for good relationships with the people whose work he directs.

Certain basic principles are foundation stones in establishing and maintaining good relations between you and those whose work you direct. Always remember to:

1. Let each worker know how he is getting along.
2. Give credit when it is due.
3. Tell people in advance about changes that will affect them.
4. Make the best use of each person's ability.

These principles apply to all workers and they do not represent actions that are to be taken only once or at rare intervals. Constantly following them in day-to-day operation will pay dividends.

Let each worker know how he is getting along. It is important to keep people posted on how they are measuring up against what is expected of them. The "everything is all right unless I tell you so" philosophy does not fit into modern supervision. The man who is doing all right should be told so. And it is often more important to check the person who is just beginning to skid. If you have to say, "You've been slipping for quite a while," you know what the worker will feel: "Why didn't you tell me sooner?"

Give credit when it is due. The worker and the department deserve to know when their efforts have contributed to an accomplishment. Recognition of good work or faithful performance makes it easier to get extra effort again.

Tell people in advance about changes that will affect them. It is not always possible for you to let a worker "in" on all decisions that affect him, but he can and should always be given the chance to "have his say." If you give the reason for changes before they are made, you will avoid many misunderstandings.

Make best use of each person's ability. Everyone likes to feel, particularly in war time, that he is working at his highest level of skill and ability. Take advantage of special interests and give each person as much and as responsible work as he can handle.

While these foundations apply to all people, you cannot let it go at "treating them all alike." No one wants to be known simply as a time-card number or as "the new man." We are all different. What happens to one operator off the job makes him different from his partner on the same job. Each of us wants to be known for his own personal characteristics.

Applying these foundations of good worker-supervisor relations will not guarantee smooth operation for you but will prevent many misunderstandings.

However, there are other things that you must consider. You need to know each individual employe and what is important to him. You need to know your people for everyday operation of your department and you particularly need this information when you have a difficult situation to handle as a job relations problem.

Because changes do occur and problems do arise, you need to have skill in handling the situations within your responsibility. Hasty action may result in a situation more difficult to handle later. When a problem arises, consider these steps as the outline for action:

1. Get the facts; be sure you have the whole story.
2. Weigh and decide; don't jump to conclusions.
3. Take action; don't pass the buck.
4. Check results; did your action help production?

Get the facts. Problems may come up because of something that happens at the moment, but you need to get the whole background. Some of it will be made up of facts about the employe—his age, length of service and experience on this job.

You will need, of course, to take into consideration both the hospital

rules and just "the way things are done here."

Remember in getting the facts you may think you know the person quite well, but if you classify him as a "good fellow" or a "chronic kicker," you are not really looking at an individual. You must regard him as a person who is different from every other person in the department, in every single aspect whether by a slight or a great degree.

As a supervisor, you must know what that man thinks and feels about himself and the people around him. Find out what the man wants: is he able or willing to express it, and what does he think should be done—and why? The experienced supervisor knows that he must also consider such other factors as health and working conditions that may be affecting the employe.

If more than one person is involved, you must go through the same fact-finding steps for each person. Before you can plan what to do, you must be sure you really have the whole story.

Weigh and decide. All these facts must be assembled and considered together. When all the factors are brought together, fitted in and considered in the light of their relations to one another, many times the right answer almost "jumps out." The wise thing to do becomes clear.

Certainly you, the department head, are in the best position to know the right thing to do, for you have a complete picture of the assembled facts. If you jump to conclusions, you make poor use of your strategic position. When you act without evaluating the whole situation, you are likely to have more difficult problems to handle later.

Take action. While jumping to conclusions is a poor way to handle supervisory problems, putting off action may be equally unfortunate. A supervisor cannot "pass the buck" or he, himself, will be by-passed.

However, it is not "passing the buck" to recognize after full consideration of the problem that there are some situations that you cannot handle yourself. You also make a decision and take action when you size up a situation as one on which you need help or recognize one which is not within your own job to handle and see that it is passed on to the person who does have the responsibility and authority.

In any action, timing must be considered—the wrong "time" can make it the wrong thing to do.

Check results. You must determine whether your action worked. If it did not, you must reexamine the whole situation and attempt to find what of importance you overlooked. Checking the results of action is necessary in every situation because conditions change and what worked with one individual will not necessarily work with another.

One of the hardest parts of your job will be that of giving consideration to the importance of people in a problem situation and knowing what is important to each individual person. This is not simply a matter of determining what is right or wrong or deciding what is just or unjust but is a practical approach to effective supervision. It may be thought to take too much time but day-by-day use of this skill in dealing with people will save time in the long run.

If you know your people well enough to build them into a smoothly operating group you will be playing an important part in the war effort.

VOLUNTEER ACTIVITIES

Flowers and Finance

A good idea can gather astounding momentum. Take the flower memorial fund of the woman's auxiliary, Rockford Hospital, Rockford, Ill. Three years ago, the fund was in its infancy and the proceeds from it were $27. Next year the flower fund brought in $112.65. Last year it totaled $1577.14.

These figures are gleaned from the auxiliary's printed reports distributed each year at the annual meeting. That three year old flower fund is now helping furnish wards and private rooms and buying hospital equipment.

Other projects that help the hospital financially are coin card drives, magazine subscription commissions and "day in the country" picnics. A new blood bank and plasma storage unit, new x-ray equipment and many refurnished rooms have been realized through this women's service group.

Thirty Years of Giving

Next year the Women's Association of Wesley Hospital, Wichita, Kan., will celebrate its thirtieth anniversary and gifts and donations are expected to pile up as the observation of that event draws nearer. These active women have contributed $140,000 to the hospital since they organized in 1915, in addition to having performed innumerable duties which cannot be measured in monetary terms.

Recent contributions include a three-deck bake oven for the hospital kitchen; draperies and other new equipment for the reception room; new furnishings and the redecorating work for the nurses' dining room; furnishings for the Pine Street nurses' home; an electric food table for the cafeteria, and an as yet uninstalled ventilating system for the nurses' dining room.

This association distributes its activities among eight committees: membership, maternity, nurses' home, crippled children, conference (a contact group among other churches in the Methodist conference), library, sewing and flower.

The maternity committee has just raised $1000 for air conditioning the birth rooms.

Mrs. S. W. Grove of Wichita is the president of the women's association.

All for Mount Sinai

Recruiting for the U. S. Cadet Nurse Corps owes much of its success to women's service groups. Mount Sinai Hospital, Chicago, has a women's board that is particularly active in nurse recruitment. It sponsors a series of teas and hospital tours for recruits and prospects.

The Infant's Aid group of this auxiliary held a luncheon meeting at the Drake Hotel on May 24, the charge being $25 a plate. A few well-attended affairs of this sort runs into really concrete aid for the infants.

With the board of directors and the medical staff, the women's board is planning a banquet to celebrate the twenty-fifth anniversary of the hospital on June 4. This is not to be a fund-raising affair.

Furniture Repair Service

Four high schools in Dayton, Ohio, through their manual arts classes, have organized a volunteer service for the repair of furniture and equipment for Miami Valley Hospital. The equipment is transported to the school shops by an adult volunteer. No estimates have been made of the number of hours donated through this unique service, but in one recent month the hospital reported that 30,806 hours had been donated by other volunteer groups.

Short of nurses?

The solution may lie in a

Closed Nursing Staff

ROBERT G. WHITTON
Administrator, Alexandria Hospital, Alexandria, Va.

SEVERAL approaches have been made to the problem of the nurse shortage in the hospitals of the country. Emphasis has been placed upon training a new source of supply, upon refresher courses for older nurses in order that they may return to the profession and upon the elimination of "luxury nursing."

After these have been done and the shortage still continues there appears to be but one conclusion: there simply are not enough nurses to go around.

The primary demands upon the nurses' time and services are to the armed forces of this country and the secondary demand is from the hospitals within the walls of which these nurses received their training and to which a sense of loyalty is due because of the joint responsibility of caring for the sick and injured.

If this is a premise, and if we are unsuccessful in recruiting nurses who are now in industrial, office or clinic nursing, then we must establish new bases for the proper nursing service to patients within the hospitals.

Private or special duty nursing is still prevalent in spite of the tendency to reduce it. Part of this condition is due to the timidity of the hospitals to enforce an obviously good rule and part to the strength of the private duty nurses within their central registries.

Hospital Supervises All Nurses

A solution to the problem as it exists in hospitals is to adopt a uniform policy of a closed nursing staff. By this method all nursing service within the hospital would be rendered by nurses in the employ and under the direct instruction and supervision of the hospital.

A patient needing special attention would be given this nursing service at the request of the doctor on the case, the administrator and superintendent of nurses concurring. The patient would be charged on his bill in the same way as for any other service rendered.

This method would permit wider coverage of cases needing nursing care. It does not make sense that every case having special duty nurses runs an even course of either eight or twelve hours. It does make sense that a case might need nursing through several difficult hours, that another case might also require attention after the crisis of the first case was past. It is, in effect, general duty nursing with the nurse assigned to give undivided attention to a number of patients in logical order, instead of divided attention to a group of patients.

At a recent meeting, the medical staff of Alexandria Hospital, Alexandria, Va., adopted the following resolution:

"Be it resolved, the medical staff of the Alexandria Hospital hereby goes on record as opposing 'luxury nursing' during the present emergency. Further, be it resolved that any nurse may be withdrawn from a case and transferred to another case if, in the opinion of the physician, the nurse is no longer needed for medical care."

Opposition to this plan will come from the organized registries. This can be partly removed by realizing that compensation is the determining factor and that hospitals must offer as much, if not more, to the private duty nurse as she receives from private cases. At the same time the pay of loyal staff or general duty nurses must be brought into line with that offered the private duty nurses.

Again, this move is in order for if we are to give and render proper care and attention to our patients we must pay for it and then pass the cost on to them through properly established rates. In other words, we must establish rates dependent upon the cost of doing business rather than have the service being given dictated by the rate established.

By limiting this move to the elimination of private duty within the hospital, those nurses who cannot do institutional work will still find enough private duty nursing on the outside, in the homes. The only deviation from this restriction might be that those who are physically unable to do general duty might take cases that show signs of being of long duration.

This plan can be made to work but it must have the blessing and support of the medical and nursing profession within a given community. A definite plan of action can come only after a round-table conference on the subject.

Solution Rests With the Nurses

It is intended as a plan offered to the nursing profession to assist in solving its problem, for it is a condition that the solution rests only within the nursing profession as it is now constituted. If the nurses have a better plan to offer it will be gratefully received. More volunteer or paid aides are not the answer, although a review of professional personnel doing nonprofessional jobs might be helpful and substitutions should be made whenever possible.

A closed staff plan cannot make nurses work, certainly not those who prefer their week ends and holidays, their evenings and nights and their several days off. It cannot force nurses to agree who prefer their independence of action to hospital supervision. It can and will permit orderly assignment of work to and by those nurses who realize their responsibilities and who uphold the standing of the nursing profession during this crisis.

It is recommended for adoption even if only for the duration.

NOTE: These remarks are my opinion only and do not in any way intend to commit the Alexandria Hospital as an institution. The board of directors has not as yet indicated any change in the present policy of general and private duty nursing.

Medical and social work students learn that there are always

Two Sides to Every Patient

ELEANOR COCKERILL
Associate Professor of Social Case Work,
University of Pittsburgh

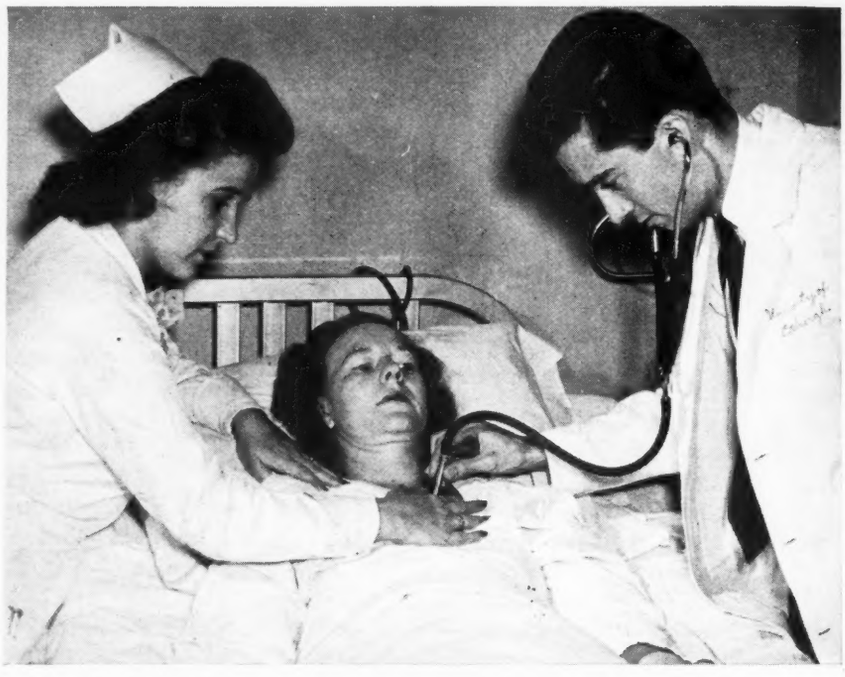
IN FEBRUARY 1943 a project was initiated by the graduate schools of medicine and applied social sciences of the University of Pittsburgh and the Presbyterian Hospital, which is part of the Medical Center and is utilized by both schools for the training of students.

This project began as an "experiment" in professional education for medicine and for medical social work. It grew out of a discussion among faculty members of these two professional schools, in which a mutual need was recognized. This discussion led to joint planning by the schools and the hospital for a merging of common interests and purposes and a sharing of resources.

Third year medical students are required, as a part of their clinical clerkship in medicine, to attend a weekly conference at the hospital in which the medical problem of a patient currently under care is discussed. Medical social work students are required in their second year of professional education to have field instruction in a hospital and also to take a course designed to help them understand the approach and methods of medical science, the philosophy of the physician and the problems that are encountered by him in the diagnosis and treatment of disease.

It was recognized that if these two groups of students could be brought together for joint consideration of the medical and social problems of a particular patient who was assigned to both a medical and a social work student for concurrent study and professional help, the specific purpose of the two required courses would be attained and, in addition, a much broader educational purpose would be served.

This class is held once a week, is one hour in length and is attended by approximately the same number of medical and medical so-



The student studies his patient preparatory to explaining the case.

Accurate data about the patient's background will help the doctor.

cial students, usually from eight to ten. It meets in a conference room adjacent to the medical wards of the hospital. The medical school instructor presides and the resident in medicine in Presbyterian Hospital, the field instructor in the social service department of Presbyterian Hospital and the medical social instructor of the School of Applied Social Sciences are present as consultants.

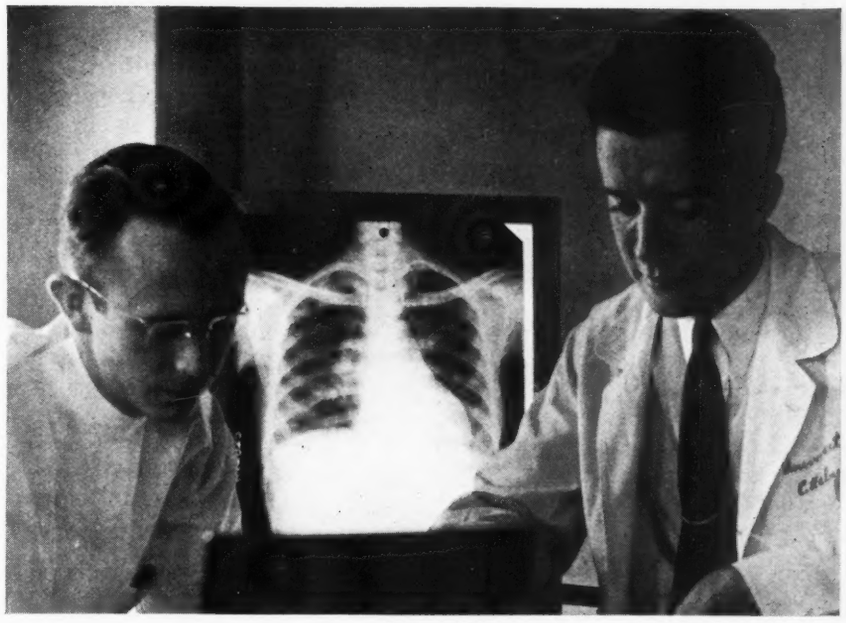
The patient, whose problem is to be discussed, is assigned the previous week to a medical student and to a medical-social student, both of whom are having supervised experience in Presbyterian Hospital in the application of their respective professional knowledge and skills to the study of the patient, to the recognition of his particular problem and to the use of the professional help that he requires.

The two students are responsible for presenting to the class the results of their study of the patient, an analysis of his problem as they see it and recommendations about the professional help that can be offered him. The usual method of clinical demonstration is employed, the patient being presented to the group in the early part of the conference and then returned to the ward when the necessary observations have been made.

The conference begins with an analysis and discussion of the information presented by the medical student, which includes a review of previous medical history, description of the chief complaint of the patient, enumeration of his symptoms, a report of the objective signs noted by the student and a summary of the findings of laboratory and diagnostic procedures.

The medical instructor calls attention to any omissions or inaccuracies in this report and questions the medical student about them. He challenges him to offer supporting evidence for his conclusions and elicits opinions from the other medical students. The student responsible for the report is asked to indicate all of the possible diseases that must be excluded in the process of differential diagnosis and to show how he has eliminated each in arriving at an opinion about the most probable diagnosis.

The medical social students are attentive listeners throughout this presentation and discussion and make



Having studied the case, the medical student must present a summary of his findings and explain just how he arrived at the diagnosis.

notes of the information that they regard as necessary and relevant for their understanding of the patient and his medical problem. Frequently, they are startled by the complexity of the medical problem, by the difficulties encountered by the doctor in identifying the specific disease from which the patient is suffering.

Because the medical instructor has assumed responsibility for making the discussion content meaningful to both groups, he frequently asks the medical student to interpret his technical statements. This request to interpret to the medical social student the medical aspects that are important for her to understand provides a real opportunity for the medical student to learn how to describe his approach to another professional person and is the beginning of a developing capacity to share. It also has a specific educational value for him because he is unable to translate medical concepts into nonmedical terms unless he understands them himself.

The medical social student becomes aware of the disciplines of the medical profession as she observes the exactness and precision demanded by the medical instructor. Her appreciation of what is involved in the process of becoming a doctor is broadened and her confidence in medical science, deepened. She also is made acutely aware of why accurate information about personal and family health history is so essential for the doctor and of the significance of diagnostic procedures in recognizing the patient's medical problem.

Through her observation of the process of diagnosis the social student becomes conscious of the fact that reliable medical help for the patient is dependent to a large degree upon the patient's own willingness and capacity to participate through giving information about himself and through cooperating in the use of diagnostic tests and procedures. Her own professional responsibility for helping the patient to cope with the problems this experience may create for him becomes sharpened and meaningful to her. She also discovers that it is often impossible and professionally unsound for a physician to give a diagnosis before there has been thorough exploration of the medical problem.

In the consideration of the kind of medical treatment that will bring relief or cure for the patient, the medical instructor draws upon the knowledge of the medical students, medical literature and his own experience as a practitioner. The usual tendency of the medical student is to offer a rather theoretical, academic plan of procedure.

The instructor recognizes the validity of this use of established and proved methods of help but he focuses the attention of the group upon the necessity for consideration of

the patient's own specific and individual needs.

"What will help *this* patient?" is the question he places before the group. The fact that disease manifests itself in varying ways in different individuals is demonstrated so convincingly throughout these conferences that the necessity for individualization of treatment becomes apparent.

However, there is always emphasis in the discussion upon certain basic essentials that must be safeguarded if the patient is to be enabled to battle successfully against the forces of disease. There is also emphasis upon the absolute necessity, in certain diseases, for the use of specific therapeutic agents that are regarded as of primary importance. The fact that, in many instances, the doctor has no specific therapy to offer and directs his attention toward providing the most advantageous circumstances for the patient's own battle with disease is recognized.

The point at which the medical social student is asked to make her contribution varies from conference to conference. When the patient's disease seems particularly obscure, she may be asked to contribute any significant material she has that will throw light upon the problem. Usually, however, she is drawn in when the discussion focuses upon treatment.

After some ideas have been developed about what may be effective treatment, the medical social student is often asked, "Do you feel it will be possible for this patient to carry out these recommendations?" or "What are the chances of this patient's being able really to cooperate with us in our plan of treatment?"

The fact that the medical social student may be called upon to contribute at varying points in the discussion provides a stimulating situation for her and one in which she must be flexible and thoughtful in her selection of appropriate and significant information. She has to develop the capacity to recognize the kind of help that the doctor is ready and able to use. She must be brief and concise in her presentation of relevant material and must focus upon the basic medical needs of the patient.

Frequently this requires a reorganization of what the student had planned to present, an orientation of her approach to that of the doctor. This is an invaluable experience for her and helps to develop a capacity for interpretation that will be essential in her future professional relationships with doctors.

The medical social student learns to focus her attention upon helping the doctor to understand his patient through the increased individualization of the patient's needs and to indicate the professional help she can offer by enabling the patient to accept medical care.

Through participation in the conference, the medical student is helped to become aware of the medical social worker's specific professional contribution to the patient and to understand how her help may be utilized in medical practice.

Hospital administrators will recognize that basic to this kind of interrelated professional education for medicine and for medical social work is a well-integrated program of medical social work within the hospital. The class method described in this article will have little significance if it is not part of a continuous plan of integrated professional care in which medical and social work staff members and students participate.

How They Handle Penicillin

METHODS of handling penicillin under the program of the Office of Civilian Penicillin Distribution (O.C.P.D.) appear to be satisfactory to depot hospitals. The reactions of other hospitals are mentioned in an editorial in this issue.

The University of Chicago Clinics, says Dr. G. Otis Whitecotton, was granted a quota of 30,000,000 units for May but has only purchased 10,000,000 units to avoid tying up too large an investment in view of possible price reductions. Present prices vary from $10 per 100,000 units to about $3.50. Certain firms with large production may soon offer a still lower price.

O.C.P.D. has arranged that hospital orders will be rotated as fairly as possible among the various firms.

At the University of Chicago Clinics, penicillin is kept in a locked refrigerator in the pharmacy. The surgical resident is made entirely responsible for penicillin use. No physician can obtain the drug until his prescription has been countersigned by this resident. A proof of use sheet is kept showing patient's name, diagnosis and proof of need.

The clinics is following directions prepared by Dr. Chester S. Keefer as outlined by O.C.P.D. in Form F. Because the clinics is a center of research, penicillin will be granted for Group II diseases (in which its position "has not been definitely defined") if careful study will be made. None is allowed for Group IV, "contraindicated" conditions.

Although the clinics rarely charges for drugs, penicillin will be charged to patients at average cost and provided free to indigents.

In one case at the clinics use of 1,000,000 units a day for three or four weeks probably saved the leg of a girl injured in a street accident.

At Evanston Hospital much the same procedure is followed except that authority is vested in Dr. Roger DeBusk, administrator. (This arrangement would probably not be satisfactory if the administrator was a nonmedical man.)

The cost has not "as yet" been included in the inclusive rate. Charges are at cost plus a 20 per cent handling charge.

Penicillin is stored in the locked blood bank refrigerator. Two sets of bookkeeping records are kept, one by Doctor DeBusk and another by the blood bank technician.

Evanston Hospital has purchased its full quota of 15,000,000 units for May.

Many requests come from patients or their relatives. Fortunately, Doctor Keefer's clear directions make it easy to handle all requests.

Henrotin Hospital likewise reports no problems. The hospital's resident is in charge and the pharmacist keeps the stock. Only one of the 6,000,000 units authorized had been ordered by May 17. Careful records of dosage and results are kept. The hospital reclaims penicillin from urine of cases using large amounts. Charges follow the regular markup in the pharmacy.

Why Minnesota Won the Award

for a public education program

MARGARET REAGAN

Director of Public Relations, Minnesota Hospital Service Association, St. Paul

IN 1943 the council on public education of the Minnesota Hospital Association and the public relations department of the Blue Cross plan outlined a year-round public educational program that developed a cooperative relationship among the Minnesota Hospital Association, the Blue Cross plan, the Minnesota State Medical Association, the Minnesota State Nurses' Association, the Red Cross and several war-time government agencies. This cooperative venture resulted in the winning of the 1943 American Hospital Association award for an outstanding hospital public educational program.

The 1944 program will be a continuation and expansion of the 1943 program and will consist of the following projects:

RADIO PROGRAM

The monthly fifteen minute radio program on Minnesota's largest radio station, WCCO, sponsoring Dr. William A. O'Brien, director of postgraduate medical education at the University of Minnesota, is being continued. Each talk deals with a specific problem of the war-time hospital and gives suggestions for hospital-public cooperation in meeting this problem.

The radio series this year is entitled "Your Hospital in War Time" and each month's program has a subtitle, such as "The Patient," "The Employe."

Superintendents again are being supplied with radio program announcement cards (double postcard style) which they send to people in their communities calling attention to the program and asking for comments. Comments so far received on the new series indicate that the public is vitally interested.

After the series is well under way, hospital superintendents will be encouraged to help create "Doctor O'Brien listening groups" perhaps among Red Cross classes, clubs and social gatherings that may be meeting on the program day. This should not be difficult to accomplish because Doctor O'Brien has a host of radio friends.

NEWS RELEASES

To ensure greater public absorption of subjects discussed by Doctor O'Brien, a news release covering the main points of the radio talk is sent each month to all newspapers in the state.

VOLUNTEERS

The underlying theme of the whole program is the alleviation of personnel shortages. Specific steps to achieve this include the following:

1. A paid high school student work corps is being organized through cooperation with boards of education.
2. Organization of volunteer hospital groups among teachers in rural and small town areas where, at present, they are a more or less untapped source is encouraged.
3. Closer collaboration is being effected with the Red Cross and Civilian Defense volunteer organizations.
4. A men's volunteer corps will be developed for orderly service and other work in which men are needed in hospitals. (One Twin City hospital is now organizing a volunteer men's group. The experience of this hospital will be made available to all hospitals in the state.)
5. Hospitals are urged to recognize tangibly and publicly the great service of the volunteer groups.

The first step in this direction was made by the St. Paul Hospital Council. An advertisement was placed in the St. Paul paper in the form of a Christmas memorandum, naming all hospital volunteer groups, publicly thanking volunteers for their work in enabling St. Paul hospitals to maintain adequate service in spite of war-time handicaps and wishing them the best of health and happiness during 1944. Other communities will be encouraged to follow this lead.

Service stripes, awarded by individual hospitals to volunteers outside the Red Cross groups after a certain number of hours of work, are being discussed.

VICTORY GARDEN

A victory garden project similar to the one inaugurated in 1943 will be carried out in 1944. A survey in 1943 indicated that 99 out of 191 hospitals wanted products from local victory gardens. The state Office of Civilian Defense then sent letters to Victory Aide chairmen in these 99 communities informing them that the local hospital wanted available produce and asking the chairman to be ready to cooperate when the hospital superintendent called.

Hospital superintendents in each of these communities received the name and address of the local Victory Aide chairman and were informed that the chairman was expecting a call and would cooperate in making surplus produce in that community available to the hospital.

NURSE RECRUITMENT

Continuing to cooperate with the Minnesota Nurses' Association, the Blue Cross plan public relations director serves on the state publicity committee and state recruiting committee of the Minnesota Nursing Council for War Service and on the local Minneapolis recruitment committee.

Accelerated recruiting is again being tied into the National Hospital

Day program of the Minnesota Hospital Association through radio, newspaper work and store displays.

Contact has been established with the General Outdoor Advertising office and the U. S. Cadet Nurse Corps story is now appearing on the billboards in Minnesota.

Plans are now being made for calling public attention to the cadet nurse corps through participation in the Minneapolis Aquatennial celebration which occurs in the midsummer. In Minneapolis, an all-city nurses' choir is being formed for participation in such civic events. Contacts are being made for a sponsorship of a cadet nurse corps float.

Cadet nurse corps recruiting is continuing in the high schools with plans being made for students to visit hospitals and for speakers to appear before high school convocations. Literature and posters are also being distributed to these groups.

Spot announcements of a local character on the cadet nurse corps are being furnished from time to time to radio stations through the O.W.I. radio packets.

The women's auxiliary of the Minnesota State Medical Association has formed a speakers' bureau and its services are available throughout the state for nurse recruitment and talks at high schools and clubs.

INFORMATION SERVICE

As part of the program, necessary articles, news releases, Hospital Day radio shows and mailings connected with the program are handled by the Blue Cross plan's public relations department.

Through the Blue Cross plan office, pertinent information, literature, speeches, articles and reprints are distributed to the public, to hospital superintendents, to newspapers and radio commentators and to the plan's 10,000 group leaders.

Through such a concentrated, coordinated program, the hospitals, the nurses and the Blue Cross plan are working together to build public knowledge and to strengthen public confidence in the ability of these organizations to meet and solve the problems of medical care in both war and peace times.

In the war on tuberculosis

LOUIS I. DUBLIN
Third Vice President and Statistician
Metropolitan Life Insurance Company

Altro Fights for Rehabilitation

IN DECEMBER 1913 a three year experiment was begun by the Committee for the Care of the Jewish Tuberculous, a committee that had been set up by a small group of men who were connected with the Montefiore Country Sanatorium at Bedford Hills, N. Y. The committee had as its purposes to provide facilities by which it would be possible to keep in close touch with those discharged from the sanatorium, to keep them under good medical supervision and, most important of all, to give them an opportunity to do productive, remunerative work under favorable conditions.

In this way, it was proposed to bridge the gap between the discharge of the patient from the sanatorium and his return to normal life in his family and in his community. Thus, was the Altro Workshop established.

What are the outstanding facts in an evaluation of the operations of Altro? It is first and foremost that those who are discharged from sanatoriums in good physical condition can, through the ministration of agencies such as this one, be kept physically well and economically productive. It is an extraordinary achievement that, ten years after graduation from Altro, 85 per cent of those who had completed their rehabilitation course were working or able to work full time.

It is no less remarkable that of all the patients who spent at least three months at the workshop, more than 85 per cent of those with minimal or moderately advanced disease were living ten years later; and even among the far advanced cases more than six out of every 10 were living a decade later. In fact, the subsequent mortality of graduates of the workshop — minimal and advanced cases taken together—has been just as low as that in the general population.

This is true likewise of all workers admitted with minimal lesions who have spent at least three months at the workshop, while workers admitted with moderately advanced disease have had a mortality only 1½ times that of the general population.

The study of Altro's experience brings out many other significant facts. The experiment has not stood still in any way. Selection of patients has changed in line with increasing medical knowledge of the disease and with the needs of the group Altro serves.

As a result, a much higher proportion of persons with advanced disease has been taken into the shops in more recent years but, despite this, general results have improved over the earlier years. It has been found that the sputum history of the patients is an important guide. Workers with far advanced lesions whose sputum is free from tubercle bacilli have a satisfactory survival rate and working record.

The story is equally good as regards recurrences. The high frequency of relapses, which was the central problem at the time of the committee's organization and which still characterizes the experience of most sanatoriums, has been radically reduced at Altro. Over a period of ten years after discharge from Altro, more than 70 per cent of the workers admitted with negative sputum had

From an address to the thirtieth anniversary dinner, Committee for the Care of the Jewish Tuberculous, April 1944.

never had a recurrence. Thus, Altro's experience abundantly demonstrates that its workers, especially those who achieve full work tolerance at the shop and are graduated into general industry, have a favorable record of health after they leave Altro. They are safe people to work with.

Few facts in the entire literature of the tuberculosis movement are as clear cut and as eloquent as these. There is, to be sure, the experience with the tuberculous employes of the Metropolitan Life Insurance Company. But they are a highly favored group. Their disease is usually discovered early; they are sent to the company's Mount McGregor Sanatorium where their expenses are paid and their sickness benefits provide for their families. These employes are taken back to work in the company on discharge from Mount McGregor, and they are watched over very much as the Altro workers are.

The Metropolitan and the Altro results are remarkably alike as to the subsequent mortality and as to the ability of the former patients to keep well and at work. A few other such fortunate groups are those at Papworth Village and Preston Hall in England.

What About the Other 75,000?

By and large, however, what is the picture? What happens to the 75,000 tuberculous who are sent out by the sanatoriums and hospitals of the United States each year? Most of these people, forced to shift for themselves, break down within a few years and, even if they return to sanatoriums to renew their cure, have much less chance of ever getting well.

The significance of the extraordinary achievement of Altro and of similar demonstrations has been passed by and has not made its impress on the programs and the daily practices of those who guide the tuberculous. The rehabilitation movement has been the Cinderella of the tuberculosis campaign.

The rank and file of those responsible for the tuberculous have known better and have done worse. They have spent hundreds of millions of dollars to build and maintain tuberculosis sanatoriums and hospitals. They have done a fairly good job in restoring large numbers of the sick to health. And they have usually stopped there.

Instead of taking the obvious next step of keeping their discharged patients under supervision and providing for graded employment and medical guidance, they have considered their job done and let these people go their way. It has been a dreadfully wasteful procedure.

Let me give you a specific illustration of how negligent has been the care of the tuberculous in terms of a group now very much in the forefront of public attention. I have in mind the veterans of World War I. Of the 4,500,000 men who were discharged from the Army, more than 200,000 who developed tuberculosis have received care for the disease under federal auspices.

Perfect Setup for Rehabilitation

Here was a large number of men who should have benefited greatly from the good will and generosity of their fellow citizens. As every one knows, the Veterans Administration has lavished huge sums of money on the care of the tuberculous veterans. Modern well-equipped hospitals were erected in beautiful surroundings. Large money benefits were paid to the tuberculous veteran and to his family. The setting was a perfect one in which to accomplish what the government hoped for, namely, to rehabilitate the tuberculous veterans both physically and economically.

Yet what has actually been accomplished? *Practically nothing!* It is true that there was a program of occupational therapy and of social service, although only here and there could a social worker attached to a hospital devote full time to that phase of the work. But the very atmosphere of the hospitals was such as to render the most perfect rehabilitation program ineffective.

Patients were permitted to go home at will, and most of them did so, discontinuing treatment against doctor's orders. Many, when they went home, were open cases and probably infected their families. Few tuberculous veterans have been discharged with their disease arrested. The Veterans Administration likewise has not supervised the veterans after their discharge. It is not surprising, then, that in spite of the solicitude of the entire nation, the tuberculous veteran has gone steadily toward complete breakdown and death.

What a contrast between the fate of the tuberculous veteran and the results achieved at Altro! Altro's contribution to the conquest of tuberculosis is a living monument to Fred Stein and his associates. They built better than they knew. I am sure that when Altro was founded they had no idea that they were tackling the most difficult of the basic problems in tuberculosis control. It was only as they progressed that they began to realize its full implications. They tackled the job to be done with good common sense. Step by step they learned how to do it, and they have done it so well that the whole world is indebted to them.

For a long time it has been my firm belief that tuberculosis would be easy to conquer if only we would make intelligent use of the knowledge we have at our disposal. Instead, we have made too much of the difficulties, which generally have been of our own creation and have reflected our limited conceptions, our lazy thinking and our niggardliness. Few have had the time or opportunity to grasp the problem of tuberculosis as a whole.

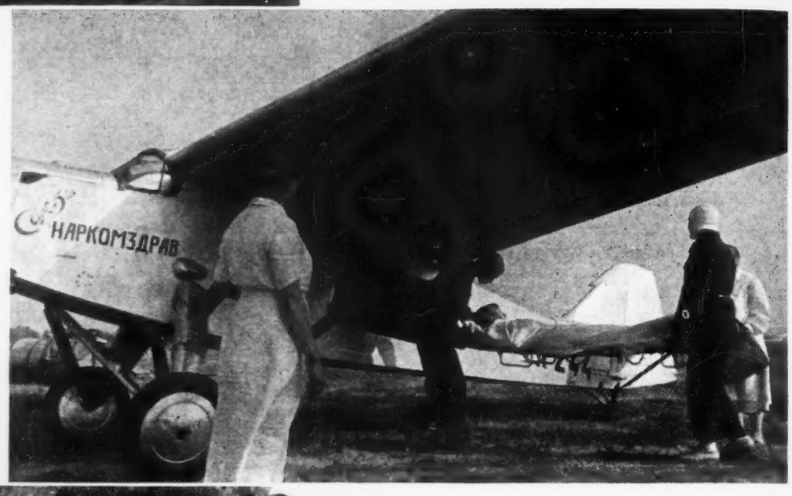
The Way Is Now Clear

Now it is possible to do it. Mr. Stein and his group have done much to bring this about. Their work is a practical demonstration of how to round out the tuberculosis campaign. Their work fits the keystone into the arch that holds the whole structure together. There is no excuse now for a truncated and partial approach to the tuberculosis problem. For just so long as we continue to work, each one in his separate compartment, we shall continue to be wasteful, indeed tragically wasteful, of the human lives that are entrusted to our care.

We must from now on conceive of the tuberculosis campaign in its fullness—from the early discovery of the sick individual to his complete restoration to health and productivity. We must, of course, first isolate the patient and safeguard the contacts. We must provide a sensible and effective method of treatment. We must see that the family is adequately provided for while the patient is "curing" and until he is able to resume the full burden of support. Finally, we must provide effective machinery for the rehabilitation of the patient, physically, mentally, economically.

A DAY in a RUSSIAN HOSPITAL

Photos from Russian War Relief



By boat, by airplane and by dog team wounded Red Army soldiers are brought to hospitals for treatment. The dog teams bring wounded men to field hospitals for care before they are sent to hospitals farther back. The plane is a civil aircraft converted into an ambulance. It is piloted by women who also serve as parachute nurses. Bottom: The patient's wounded leg is stretched under the guidance of the chief surgeon who instructs one of the volunteer aides, soon to give the exercise herself.

IN THIS Russian military hospital, supported by Americans through Russian War Relief, gymnastics are a daily routine. Wounded men are put through rigid sets of exercises especially designed to bring into play muscles that have been injured. Individually and in classes the soldiers go through their paces under the guidance of women instructors, most of them trained athletes, champion runners, swimmers, acrobats and hockey players, who serve as hospital volunteers.

Physical therapy is highly favored by Russian doctors to restore seemingly hopelessly paralyzed limbs. No more than four or five days after entering a hospital, the patient with an incapacitated limb starts on a program of physical activity that is slowly increased until he is ready to be discharged.

In one case a soldier with a broken pelvis is reported to have been walking again after only one month of exercise.

For the bed-ridden soldier exercise is a morale booster as well as a health restorer. In this hospital only 0.7 per cent of the patients are

Exercise Returns Them to the Front

Above, left: Hockey Player Maslova, a regular volunteer at this hospital, helps the soldier exercise his healthy leg and abdominal muscles. Above, right: Daily exercise cheers the patients and keeps good muscles fit and firm. Below, left: Basketball is often played by patients who cannot yet sit up in bed. Below, right: The happy ending. The soldier, now fully recovered, receives the good wishes of some of the personnel before returning to duty.

incurable and return to civilian life. Another 2.3 per cent of the patients go into noncombatant service and 97 per cent of the soldiers are able to return to active battlefront duty.

At the front millions of Russian soldiers wear wound stripes on their sleeves. They represent a vast army of wounded, raised by Russian doctors who have performed a medical miracle as outstanding as the military successes of the Red Army.

For this miracle Americans are partly responsible. Through Russian War Relief more than $6,000,000 worth of drugs have already been sent to the Russian front and each month additional shipments are made.

Among supplies sent are quantities of sulfapyridine, sulfanilamide, lanolin, strophanthin, caffein, insulin, tannic acid and all types of x-ray equipment and surgical instruments, in addition to such vital necessities as soap, hot water bags and safety pins.

As a result of military casualties numbering well over 7,000,000 and civilian losses of at least 10,000,000, the Russians' own medical resources have long since reached the vanishing point, but today 1718 evacuation hospitals and 268 base hospitals are partially equipped with American supplies.

Administrators

Dr. I. S. Hneleski has been appointed superintendent and medical director of Philadelphia General Hospital, succeeding the late **Dr. William G. Turnbull.** Doctor Hneleski was made chief resident at the hospital in 1931, a position he held until his appointment as superintendent. He is an active member of the county medical society and of the American College of Physicians.

Harold A. Sayles has resigned as superintendent of Pontiac General Hospital, Pontiac, Mich., to accept a position as assistant administrator of the University of Maryland Hospital, Baltimore.

Dr. E. K. Steinkopff, formerly head of the tuberculosis division of the Illinois State Board of Health, has been named medical director of Pinehurst Sanatorium, Janesville, Wis., of which **Iva L. Hartman** is administrator.

Victor S. Lindberg, who has been superintendent of Victory Memorial Hospital, Waukegan, Ill., since 1938, has resigned that position to become head of Memorial Hospital of Springfield, Ill., succeeding **R. E. Raper.** Mr. Lindberg, a nominee of the American College of Hospital Administrators, is active in hospital association activities in Illinois. He has served on the executive committee of the Tri-State Hospital Assembly since 1940 and has also been secretary-treasurer of the Illinois Hospital Association since 1940.

Rev. A. E. Lyman-Wheaton has been appointed superintendent, Christ Hospital, Jersey City, N. J., succeeding **Ernest Schultz** who has resigned on account of poor health. **Walter K. Hargreaves** has been appointed assistant superintendent. Mr. Hargreaves formerly was associated with the Brooklyn Hospital, Brooklyn, N. Y.

Dr. Eugene B. Elder, who was for eight years superintendent and business manager of Baroness Erlanger Hospital, Chattanooga, Tenn., has accepted the post of superintendent of Flagler Hospital, St. Augustine, Fla., succeeding **Dr. T. Dwight Sloan,** who has resigned because of ill health. Doctor Elder is a fellow of the American College of Hospital Administrators and of the American Medical Association. He was a charter member of the Tennessee Hospital Association and served as secretary-treasurer and as president.

Mrs. Virginia Dunn has resigned as superintendent of Knox County General Hospital, Rockland, Me.

Paul Fleming, administrator of Hahnemann Hospital, San Francisco, has been appointed assistant director of New Haven Hospital, New Haven, Conn., succeeding **Dr. Reo J. Marcotte.** At the same time announcement was made of the appointment of **Dudley Porter Miller** as successor to **Richard O. West.** Mr. Miller has for the last two years been administrative assistant to the director of the department of applied physiology, Yale Medical School.

Dr. E. B. Key on May 1 assumed the duties of administrator of Matty Hersee Hospital, Meridian, Miss., succeeding **Dr. C. M. Gully.**

Dr. F. E. Sadler recently accepted the post of superintendent of Oklahoma State Veterans Hospital at Sulphur, Okla.

Jane Currie, formerly director of nurses at Sheldon Memorial Hospital, Albion, Mich., has been appointed administrator of Central Michigan Community Hospital, Mount Pleasant, Mich.

Josephine M. Hoover, R.N., is the new administrator of Shelby Memorial Hospital, Shelby, Ohio. Miss Hoover was formerly administrative supervisor of Maternity Hospital, University Hospitals, Cleveland. She received her bachelor of science degree from Western Reserve University in 1942.

The first issue of a medal in honor of Mary Adelaide Nutting, professor emeritus of nursing education, Teachers College, Columbia University, was awarded to Miss Nutting by the National League of Nursing Education. It was presented by Stella Goostray, president.

Dr. Charles C. Weaver has accepted the position of administrator of Hugh Chatham Memorial Hospital, Elkin, N. C., succeeding **W. M. Smith.**

George R. Darden, secretary and business manager of James Walker Memorial Hospital, Wilmington, N. C., became administrator of that institution on May 1.

Lois Huffman Martin, R.N., has been appointed administrator of Alva General Hospital, Alva, Okla. Miss Martin was previously associated with the U. S. Public Health Service and with City-County Hospital, Fort Worth, Tex.

Dr. John F. Regan, former assistant superintendent, State Hospital for Mental Diseases, Howard, R. I., has been named superintendent of that institution, succeeding **Dr. John R. Ross.**

Department Heads

Winifred R. Clarke, R.N., has been appointed supervisor of nurses at Meriden Hospital, Meriden, Conn. Mrs. Clarke was formerly supervisor of nurses at Eastern Maine General Hospital, Bangor.

Grace Gish Appleton has recently been appointed director of nursing education, State Teachers College, Plattsburg, N. Y.

Dr. D. H. Dewey has been elected chief of staff of Owatonna City Hospital, Owatonna, Minn., succeeding **Dr. J. F. Schaefer.**

Mary M. King, R.N., recently assumed the duties of director of nursing and principal of the school of nursing at New Rochelle Hospital, New Rochelle, N. Y., succeeding **V. Hope Dick.** Since 1941 Miss King has been associated with Harlem Valley State Hospital, Wingdale, N. Y., as assistant and later as principal of the nursing school.

Louis Slatin has been named assistant personnel executive at Montefiore Hospital, New York City.

Miscellaneous

W. H. Lichty, enrollment director of Michigan Hospital Service for the last five years, has been named executive director, succeeding John R. Mannix. Mr. Lichty was employed to head the enrollment department of the Michigan plan when the number of subscribers totaled 14,000; that figure has since been raised to 1,118,000.

(*Continued on Page* 160)

Public Health interests small hospitals, too

A SURPRISING amount of cooperation by small hospitals in public health work is indicated by the 11 replies to a questionnaire on this subject sent out to 50 hospitals by The MODERN HOSPITAL. Perhaps only those that were already somewhat interested took the trouble to answer.

Nine of the 11 hospitals reported that they cooperate in some way with the public health program of their city, county or state. Cooperation ranges through a long list of items. Four hospitals maintain tuberculosis clinics, three have clinics for crippled children and two provide clinics for well babies, mental hygiene and tumors. Other types of clinics (each reported by a single hospital) are: venereal disease, genito-urinary, tonsils, vaccination and inoculation, and prenatal instruction. One also reports that it cooperates with general clinics maintained by the public health department (eye, ear, nose and throat and prenatal.)

Other types of cooperation (each mentioned by one hospital) are: participating in the emergency maternal and infant care program; providing space for a community blood bank; autoclaving obstetrical kits for the county health department; doing spinal taps for the county health department; cooperating with the school of nursing of the University of Colorado which, in turn, is affiliated with the county public health nursing service; sending students to the local public health center to assist with inoculations; distributing leaflets regarding the visiting nurse service to patients on their discharge from the hospital, and permitting hospital personnel to teach in health education classes.

All 11 of the hospitals stated that they think small hospitals should cooperate in the local public health program. In addition to the items previously mentioned, the following methods of cooperation were suggested: health education and particularly giving instructions on the care and prevention of communicable diseases, reciprocity in providing services, case-finding work in tuberculosis and venereal disease, treating the indigent, providing office space for the public health department.

One administrator suggests that the hospital could well supplement the limited funds of the public health unit in a small town. Raymond Hosford goes further: "In many small communities the health department is inactive. Perhaps the hospitals should take the initiative in organizing a public health program and in stimulating and encouraging local health officers to action."

With the federal financial assistance that is now available under the Social Security Act plus the trend toward using counties or unions of several counties as the territory for a local public health unit, this stimulation should be effective. Certainly, a hospital would be earning public respect by taking leadership in such a program.

The final question reads: "Have you consulted your local health officer to find ways in which you might cooperate in the public health program?" Three said "yes" and eight said "no." The comments of four were that they are too busy now with the limited staff available to undertake any new projects. Miss Ditt reports that she is working sixteen hours per day for seven days a week because of the shortage of nurses.

Other comments include:

"The health officer knows we are ready to cooperate."

"Our health officer attends staff meetings and public health nurses give lectures to our nurses."

"The health officer has his office in a competing hospital."

"More complete cooperation could be had if the Wagner-Murray-Dingell Bill would become law."

"There is mutual understanding as to public health problems in the city and within the hospital. At the present time, there is some scheme afoot for the hospital to take over the local isolation hospital."

One administrator summarizes his views as follows: "The government *is* public health minded; hospitals *should be* public health conscious. If the voluntary hospitals fail to take advantage of their opportunity to broaden their sphere of usefulness, then the government will certainly step in and run the program."

THANKS TO THESE CORRESPONDENTS

HOSPITAL	PERSON REPORTING	CAPACITY
Bishop Randall, Lander, Wyo.	Mrs. E. Hainworth	20
Empress Cottage, Empress, Alta.	Marion Flock	24
Orleans County Memorial, Newport, Vt.	Mrs. Jean Fenton Cromwell	32
Community, Big Rapids, Mich.	Amelia Ditt	46
Houston, Houston, Miss.	John Dyer, M.D.	50
Mennonite, La Junta, Colo.	Rev. Allen H. Erb	70
Community, Elk City, Okla.	M. Shadid, M.D.	100
Memorial, St. Thomas, Ont.	Rhano M. Beamish	107
Jane Lamb Memorial, Clinton, Iowa	Margaret Kirkpatrick	115
Lutheran, Brooklyn, N. Y.	Augusta E. Abel	120
Bradford, Bradford, Pa.	R. F. Hosford	140

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Speaking of Public Relations

For the benefit of other trustees who are considering expanding their public relations programs, Mr. Delafield tells how his hospital approaches the problem of telling its story to the community

By EDWARD C. DELAFIELD
Treasurer, Memorial Hospital, New York City

as told to RAYMOND P. SLOAN

WERE the average hospital trustee to apply the same knowledge of organization and management to the hospital that he does to his own business affairs how much greater would be his contribution! The reason that he doesn't may be easily explained. There is little in the hospital picture as he sees it to challenge him, and the average business man responds most effectively when challenged.

Frequently, the hospital is an unknown quantity to the trustee. He has been led to believe that these institutions must necessarily operate in the red and quite naturally he thinks in terms of favorable financial statements. His natural impulse is to promote and to sell a commodity. As impressed as he may be with the importance of health service its intangible qualities, plus its professional complications, cause him to retire bewildered, frustrated — merely one more trustee.

Suppose, however, that this trustee were made to realize that hospitals need not necessarily show tremendous deficits, or that such deficits may be reduced through the application of sound business methods. Suppose he were shown that aside from the physical care of the patient, the modern hospital has educational functions to perform, scientific research to conduct in its laboratories and public health programs for which it is responsible. Immediately he would see before him a challenge, an opportunity to serve. The name "hospital" even, he would agree, seems inadequate in interpreting correctly its manifold functions.

Trustees, like others, respond in varying degree to different challenges. To some it may be the financial problem that awakens in them the desire to fight; to others it is the challenge of better health, of helping to conquer some specific disease.

As a trustee of a special disease hospital I can speak best of the challenge that has confronted me and every other member of our board. For centuries mere mention of the word cancer had struck terror into the hearts of men and women. It was a subject to be shunned as were its unfortunate victims. Here, then, was a battle to test the mettle of the stoutest heart, a fight to assuage the fears that this dread disease precipitates and to prove that taken in time under scientific treatment it need not be fatal. What better cause for which to take up arms!

There was a story to be told about the work that was going on at Memorial Hospital, New York City, and to tell that story effectively required professional assistance. Mention public relations to the average business man and he feels thoroughly at home. Unfortunately, he does not always see the parallel between public relations in his own business or profession and public relations as it applies to the voluntary hospital.

There were steps to be taken before a so-called public relations program could be instituted at Memorial. First, it was necessary to convince conservative members of the medical profession that cancer should be publicized, that reports of research groups should be presented and information disseminated regarding the facilities available for early diagnosis and treatment. This had to be accomplished slowly, for the word "publicity" raises suspicion in the hearts of most medical men.

Gradually this opposition was broken down. With the opening of a new building, constituting the largest and finest cancer hospital in the world, it became apparent that there was definite need for a public relations department with someone in charge qualified to coordinate the entire program and in whom everyone would have confidence. In bringing this about we were fortunate in having the counsel of a man on the board who is a journalist of international reputation and who devotes a considerable portion of his time to this work.

Today, public relations is an accredited department at Memorial.

We have grown to recognize that this work is as essential to a modern voluntary hospital, particularly a special hospital, such as Memorial, as it is to any business corporation. A corporation is owned by its stockholders who expect a return in the form of dividends on their investment. A voluntary hospital is owned by its contributors who expect dividends in the form of health for its patients. Thus, the voluntary hospital has a responsibility to the contributing public just as the business corporation has to its stockholders.

For the benefit of trustees who, as part of their postwar planning, may be considering the organization or expansion of their public relations program it may be of interest to know something of the setup of this department at Memorial.

The functions of this office are threefold. Its first responsibility is to keep the community advised of the progress of hospital work, to educate the public on new developments and familiarize it with the institution. The result of publicity, that is the right kind of publicity, is good will for the hospital and greater support by the community.

The control of publicity is important for every institution, but particularly for the special hospital. News of advances in research must be investigated and authenticated for the public. Many demands are received for various types of stories, some legitimate, some definitely bad and many indifferent. Proper handling can place these all in the first category and save many headaches. It is not a question of how much publicity the institution receives but of the kind of publicity it receives and the extent to which it is actually educational.

Tell New Developments

Promotional publicity is especially valuable. By this is meant the dissemination of information covering a new development in controlling some specific disease. Here is a life-saving activity that is of the utmost importance to the public and that is destined to arouse widespread interest. Also under the heading of publicity should be included booklets, pamphlets and reports.

The second function of Memorial's public relations department bears directly upon personnel relations, for successful relations with the public has its roots in a well-administered hospital family. Here, again, is a subject that the average trustee can easily understand. Each employe who deals with the public has it within his or her power to do a public relations job for the institution. He can make a friend or foe. Employes, therefore, should be selected and governed with this in mind. Workers should believe in what they are doing and have confidence in the administration.

Improves Public Attitude

Because it is somewhat apart from the administration, the public relations department frequently can see and make suggestions that will ultimately improve or develop a better attitude on the part of the public toward the hospital. Many individuals who have been helped by the hospital or who for one reason or another are interested in its work may wish to make some form of contribution.

It is the function of the public relations department to guide the interest of such people and, at the same time, to cultivate the interest of others through publicity, lectures, teas and other functions. Public relations cooperates with other agencies always with the idea of furthering good will, public education and subscriptions.

This brings us to the third and final function of the public relations department—cooperation in gaining financial support for the institution. It must provide the background for fund raising and the investigation and development of avenues for obtaining contributions. It must see to it that all booklets and pamphlets issued by the hospital are produced with an eye to their financial promotional value. Present contributors must be encouraged to give more and new prospects must be added to the list. The basis of support for the hospital must be broadened constantly.

So it will be seen that the presence of a public relations department means much to the success of an institution engaged in medical care, particularly to one concerned in medical research. Whereas the pattern must be adapted to the needs of the individual hospital the general picture remains the same. It is a picture, too, that the trustee can appreciate. He has a similar one, no doubt, set up in his own business organization.

Applying the same knowledge of corporate organization and management he has gained through the years in the conduct of his own affairs to the operation of the hospital, the trustee will ultimately arrive at other conclusions if he has not already reached them.

Small directorates are easier to handle than larger unwieldy groups, and great care should be exercised in making appointments. Reference has previously been made to the contribution of one Memorial trustee who by reason of his professional background has been of inestimable help in guiding the public relations program. Specialized knowledge is always an asset.

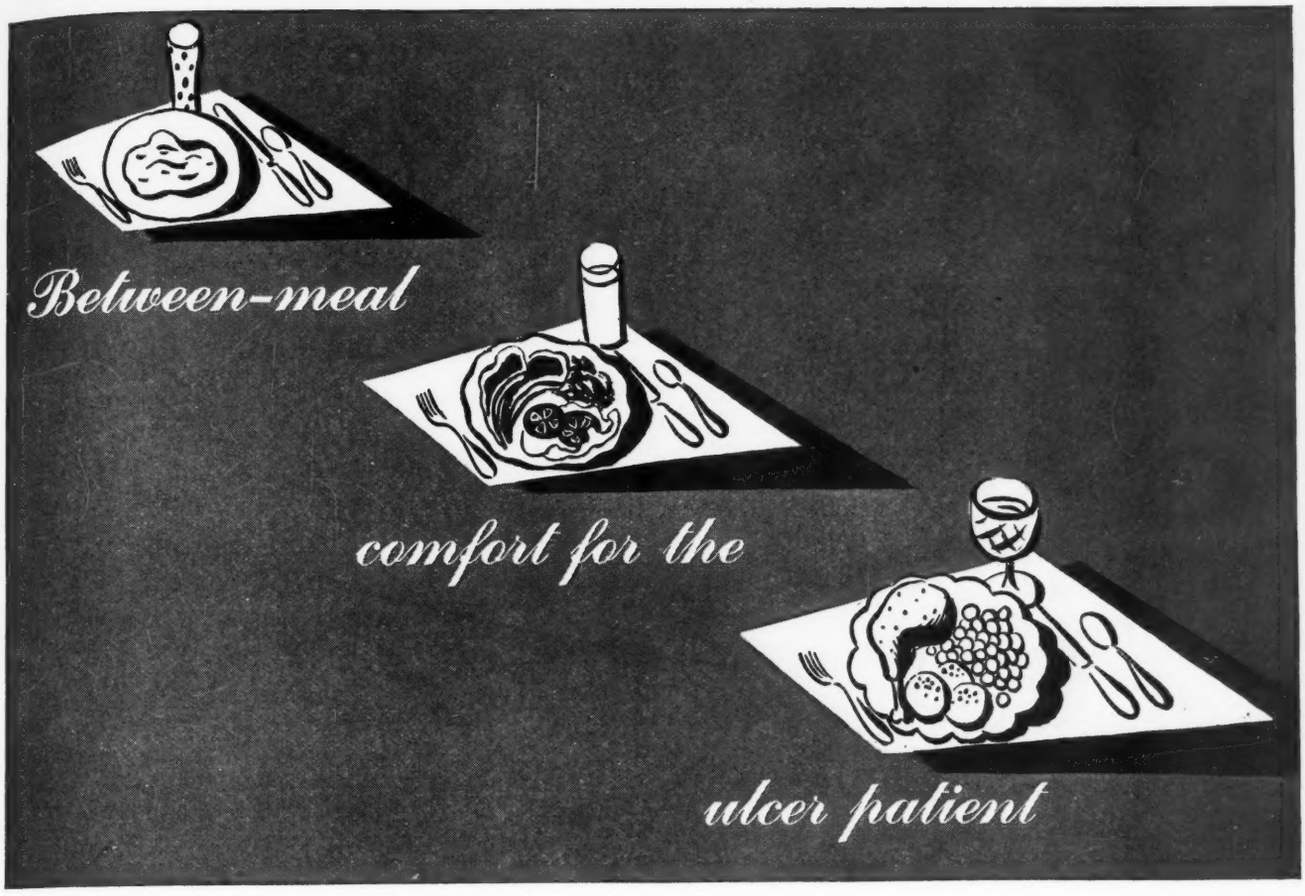
Tenure of office is another matter that deserves serious consideration. A stipulated term of service, three years for example, with reelection by unanimous action on the part of the governing body should assure the right kind of support and eliminate any deadwood that may develop.

The question of age is sometimes raised, some contending that a limit should be imposed. This is difficult to govern because one man at 70 may be more alert mentally than another at 60. So much depends upon the individual.

Mature Judgment Is Needed

There are those, too, who would promote the presence of young men on the board. This also depends upon the individual but it frequently happens that the young man who has not yet "arrived" is too engaged with his personal affairs to assume many outside obligations. Furthermore, mature judgment is required because, whether or not it is as fully recognized as it should be, hospital stewardship involves grave responsibilities.

What the hospital board member needs to help him discharge his responsibilities with distinction is a challenge, something to fight for. Whether that challenge takes the form of changing the color of the financial statement, promoting better public health or waging war against some specific disease makes little difference. With a fight on his hands, something to strive for in which he has supreme faith, the average trustee will function satisfactorily.



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—Geriatrics Series—

Physical Therapy
comes to the aid of the aged
Part II

DON J. ERICKSON, M.D.
Fellow in Physical Medicine
Mayo Foundation
Rochester, Minn.

FRANK H. KRUSEN, M.D.
Section on Physical Medicine
Mayo Clinic
Rochester, Minn.

CARDIOVASCULAR diseases rank second in causing prolonged and progressive disability in the aged. To relieve a failing heart, rest is necessary. In the presence of cardiac decompensation, massage is an aid to the peripheral flow of blood in that it tends to assist the return of venous blood to the heart. It can be employed as a partial substitute for exercise when patients are to have absolute rest in bed.

Closely supervised exercise is an important factor in the care of ambulatory patients who have cardiac disease. According to Kovács,[15] when the patient is confined to bed, mild exercise may aid more than stimulate the heart, provided cardiac decompensation is not too great.

Physical therapeutic measures are eminently suitable to combat the cardiac neuroses. The use of sedative baths and of local heat, either radiant or diathermy, is indicated when nervous tension exists. These same measures are useful in alleviating pain of the thoracic wall simulating heart disease.

It must be remembered that baths must be prescribed carefully to the aged, because a cold bath (85° F.) increases peripheral resistance and cardiac work, whereas a warm bath increases heart rate, lowers blood pressure and causes coronary insufficiency. Such baths are contraindicated in the presence of coronary disease.

The use of diathermy over the heart for angina pectoris and over the kidneys for hypertension of renal origin has been recommended but the results are inconclusive, according to Kovács.

Peripheral vascular disease is becoming of great importance in medicine because it is a common cause of disability and illness among elderly people, as pointed out by Piersol.[16] Atheromatous plaques of peripheral arteriosclerosis may enlarge slowly to compromise the lumina of vessels and cause gradual occlusion or may suddenly undergo subendothelial hemorrhage and cause rapid occlusion.[17] The lower extremities are affected most commonly. Symptoms are due to anoxia of the tissues caused by an inadequate supply of blood; commonly, a certain degree of spasm is present in addition to the organic changes.[18]

Simple tests, such as palpation of the peripheral arteries, noting the changes of color on elevation and dependency and measuring the venous filling time in the feet, are useful in evaluating the amount of occlusive disease present.

The various physical measures that have been recommended have been used for the purpose of improving circulation to the involved region by causing vasodilatation of the active vessels and widening of the collateral vessels. At the same time, it must be remembered that the skin and underlying tissues of an extremity affected by peripheral vascular disease are especially vulnerable to injury by mechanical and chemical agents. Barker[19] reported that the precipitating cause of ulceration and gangrene in approximately 39 per cent of 171 cases of thrombo-angiitis obliterans was ill-advised therapeutic procedures.

Rest is of the utmost importance in the cases in which there is a serious impairment of circulation. Rest is also essential in acute embolism or thrombosis. For the greatest benefits the extremity is placed at a level of the greatest circulatory efficiency. This is determined by changing position and finding the level at which the veins just fill, usually about 6 inches (15 cm.) below the level of the heart.

When less serious impairment is present or when treatment is started in the early stages of the disease, postural exercises are useful to improve circulation. Those recommended by Buerger[20] consist in principle of having the patient lying flat in bed, first elevating the legs, then lowering them over the edge

Other articles in this series on geriatrics that have appeared in The Modern Hospital within the last year are: "Care of the Patient's Skin," C. G. Lane and I. H. Blank, January 1943; "Let's Keep the Old Gray Mare in Harness," Clifford V. Mason, M.D., February 1944; "Dentistry for the Aged," Carl O. Flagstad, D.D.S., March 1944; "Tuberculosis Strikes at the Aged, Too," J. Arthur Myers, M.D., April 1944, and "Food for the Aged," May 1944.

[15]Kovács, Richard: Electrotherapy and Light Therapy With the Essentials of Hydrotherapy and Mechanotherapy, Ed. 4, Philadelphia, Lea & Febiger, 1942, pp. 735.

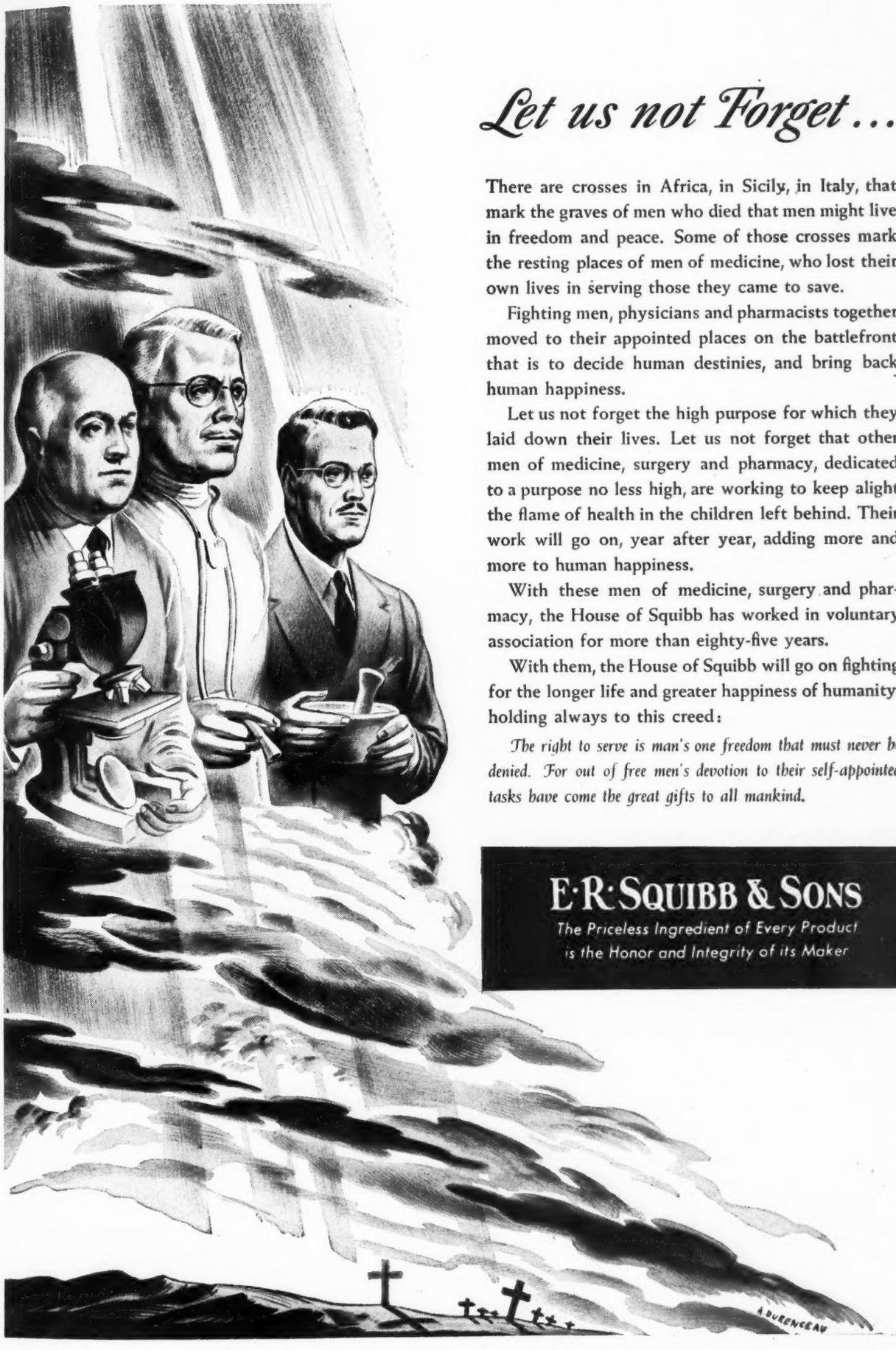
[16]Piersol, G. M.: Arteriosclerosis; Social Significance and Recent Advances in Treatment, Bull. New York Acad. Med. **18:**36-52 (Jan.) 1942.

[17]Schlossmann, N. C., and Gerber, Leon: Peripheral Arteriosclerosis, Ann. Surg. **115:** 292-307 (Feb.) 1942.

[18]Lewis, Thomas: Vascular Disorders of the Limbs, New York, The Macmillan Company, 1936, pp. 111.

[19]Barker, N. W.: The Danger of Gangrene of the Toes. J.A.M.A. **104:**2147-2149 (June 15) 1935.

[20]Buerger, Leo: The Circulatory Disturbances of the Extremities, Philadelphia, W. B. Saunders Company, 1924, pp. 628.



Let us not Forget...

There are crosses in Africa, in Sicily, in Italy, that mark the graves of men who died that men might live in freedom and peace. Some of those crosses mark the resting places of men of medicine, who lost their own lives in serving those they came to save.

Fighting men, physicians and pharmacists together moved to their appointed places on the battlefront that is to decide human destinies, and bring back human happiness.

Let us not forget the high purpose for which they laid down their lives. Let us not forget that other men of medicine, surgery and pharmacy, dedicated to a purpose no less high, are working to keep alight the flame of health in the children left behind. Their work will go on, year after year, adding more and more to human happiness.

With these men of medicine, surgery and pharmacy, the House of Squibb has worked in voluntary association for more than eighty-five years.

With them, the House of Squibb will go on fighting for the longer life and greater happiness of humanity, holding always to this creed:

The right to serve is man's one freedom that must never be denied. For out of free men's devotion to their self-appointed tasks have come the great gifts to all mankind.

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of the bed and finally resting them on the bed. The timing depends on the color changes. The exercises are most effective if used over a long period.

The proper use of baths is advocated in the management of peripheral vascular disorders. Warm soaks are used in cases of gangrene or ulceration. The temperature should never exceed from 102 to 105° F. Boric acid is the most commonly used solution.

The use of contrast baths is based on the hypothesis that the patient's vessels are exercised by the changes of temperature. The temperature of the warm bath should be from 100 to 105° F. and that of the cold bath never less than from 60 to 70° F. Five to seven alterations are given with four minutes in the hot and one minute in the cold.

These baths sometimes aggravate the pain by causing vasospasm that may persist; also, the level of block may be above the part in the bath and ability to respond may not be realized at the level of the stimulus. Instead, sitz baths are recommended by Wright[21] because they overcome all objections to the contrast baths.

The patient sits in a tub containing 12 inches (30 cm.) of water at a temperature of 105° F. for from twenty to thirty minutes. Sitz baths are not suitable, however, if an ulcer or gangrene is present. Whirlpool baths are useful in the treatment of ulceration. The temperature of the water should be the same as for the sitz bath.

Local heat is used to reproduce the normal surface temperature, which never exceeds 95° F. Therefore, great caution must be exercised in the application of local heating devices. A thermostatically controlled heat cradle is a safe method. The local use of heat lamps, diathermy or other methods of heating is to be condemned.

Reflex heating can be used to increase peripheral circulation, as well as to determine the potential vasodilatation of a vascular tree. Bennett, Hines and Krusen[22] have shown that the application of short-wave diathermy over the lumbosacral region will produce considerable vasodilatation of the lower extremities as demonstrated by studies of cutaneous temperature. This reflex vasodilatation will be dependent on how much the diseased arteries can dilate.

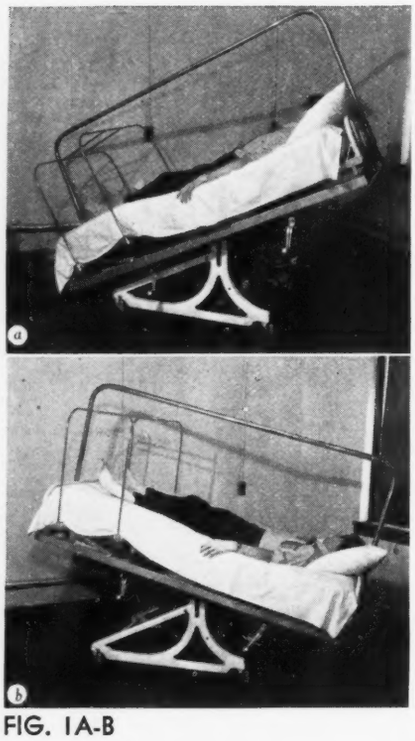


FIG. 1A-B

Many mechanical therapeutic measures have been devised for the treatment of peripheral vascular disease. Intermittent venous occlusion has been employed for a number of years in the treatment of peripheral vascular disease. A pneumatic cuff is placed around the extremity and is inflated to a point at which it produces venous occlusion. The cuff is alternately inflated and deflated for a given length of time. Following the period of constriction there is a short period of reactive hyperemia in the extremity.

The alternate suction-pressure apparatus is a machine with a pump that is driven by an electric motor and which, in turn, is attached to a chamber into which the extremity is placed. The chamber is closed at the open end by a cuff that fits snugly around the extremity. The pressure in the chamber is alternately increased and reduced. According to Wright, his experience with the machine has narrowed the indications for its use. Also, recent studies by Wilkins and Friedland[23] have shown that it is doubtful if there is much improvement of blood flow by use of this apparatus.

The Sanders oscillating bed permits the patient to have passive vascular exercise over an indefinite period (Fig. 1a-b). In addition, a thermostatically controlled heat cradle over the legs can be used as an adjunct. An evaluation of these methods on the basis of skin temperature studies has been made by Horton, Sheard and Krusen,[24] who have stated that "If any type of apparatus is used in the treatment of peripheral vascular disease, this treatment can be accomplished best by the use of an oscillating bed, provided the room temperature is from 85 to 87° F. at which temperature vascular spasm ceases to exist in the involved extremities."

Iontophoresis with vasodilating drugs is finding an increasing use in the treatment of peripheral vascular disease, especially when vasospasm is present, according to Kovacs.[25] Caution in its use must be exercised in treatment of old people.

Vascular accidents are an important cause of disability among the aged. As a result of senile changes in the central nervous system, various symptoms may appear, such as disturbance of gait and paresthesias.

Hemiplegia is usually a result of cerebral hemorrhage, embolism or thrombosis. The use of physical therapy is indicated even in the acute phases, in which application of mild heat and light sedative massage may afford relief of pain and relax the spastic muscles. Faulty position, that is, wrist drop or foot drop, is corrected by supports. Exercise should be instituted early with gentle passive movements and, later, active and active assistive exercise should be begun as muscular power returns.

It should always be borne in mind that the purpose of this exercise is to improve muscular coordination as well as to strengthen weak muscles and to stretch the stronger spastic ones. Here, a walker may be helpful for aiding the patient when he first begins to walk. Later a cane is used for support.

[21]Wright, Irving: Conservative Treatment of Occlusive Arterial Disease, Arch. Surg. **40**:163-189 (Feb.) 1940.

[22]Bennett, R. L., Hines, E. A., and Krusen, F. H.: Effect of Short-Wave Diathermy on the Cutaneous Temperatures of the Feet. Am. Heart J. **21**:490-503 (April) 1941.

[23]Wilkins, R. W., and Friedland, C. K.: Peripheral Vascular Disease, New England J. Med. **229**:16-22 (July 1) 1943.

[24]Horton, B. T., Krusen, F. H., and Sheard, Charles: An Evaluation of Methods and Mechanical Devices Used in the Treatment of Peripheral Vascular Diseases, Arch. Phys. Therapy. **22**:389-402 (July) 1941.

[25]Kovacs, Joseph: The Iontophoresis of Acetyl-Beta-Methylcholin Chlorid in the Treatment of Chronic Arthritis and Peripheral Vascular Disease, Am. J. M. So. **188**:32-36 (July) 1934.

Patients are encouraged to do more and more of the usual activities, such as housework, so as to regain strength and confidence. The physician should be watchful of the patient to see that contractures are prevented or minimized even if splinting is used during sleep. Changes in the spinal cord may consist of degenerative conditions similar to those seen in cases of pernicious anemia, as Camp[26] has pointed out. A spastic type of incoordination develops.

Frenkel exercises are of considerable value when incoordination is present. These may be preceded by the use of heat and massage. Caution must be observed in the use of heat. These same exercises may be useful in slow, hesitating gait of old age (senile abasia).

[26]Camp, C. D.: Geriatrics, J. Michigan M. Soc. **38**:289-295 (April) 1939.

Curare-Like Drugs

HENRY SCHWERMA, M.D.

Pharmacology Department, Wayne University, Detroit

EVER since Claude Bernard, about a century ago, clearly demonstrated the peripheral paralyzant action of curare on skeletal muscle there has existed the hope that this drug might be of clinical use in the treatment of various spastic states of skeletal muscle. But this hope has not yet been realized for the small amount of curare obtainable has always been exceedingly variable in potency and in its properties because of the admixture of various alkaloids. Although many attempts were made, it was only a few years ago that the active principle was isolated in pure form.

It is not strange then that a search was begun for plants from which could be extracted curare-like substances abundant in quantity and pure in form. As early as 1877 it was found that extracts of seeds of erythrina, a Central American shrub, had a paralyzing effect in animals. For many years this work was forgotten. Within the last decade, however, the curare-like action of erythrina extracts had been rediscovered and several groups of workers have been investigating the pharmacological activity of many species of this plant.

From this work have emerged a few alkaloids that may find some use in clinical medicine. One of these is erythroidine, derived from Erythrina americana (Mill) which has been used in its natural form, since it is more readily obtained pure than is its isomer. Several hydrogenated derivatives of erythroidine have been prepared; of these dihydroerythroidine is most potent, surpassing erythroidine itself.

In the acute toxicity studies on these two alkaloids the toxic manifestations were the same. Peripheral respiratory failure was invariably the cause of death; the heart continued to beat for several minutes after respiration had ceased. As in curare poisoning the cats and rabbits used in this study were at first unable to hold up their heads and then were unable to stand. As the drug reached the intercostal muscles the animals were reduced to diaphragmatic respiration alone. Finally this became irregular and ceased. Dihydroerythroidine was between two and ten times as toxic as erythroidine. In contrast to curare, these drugs are as effective orally as parenterally.

In assaying the curarizing potency of these alkaloids frogs were used in much the same manner as in the classic experiments of C. Bernard. After intralymphatic injection of the drug the effect was determined by faradization of the sciatic nerve. An effective dose prevented muscular contraction, which could be elicited only by the direct stimulation of the muscle. The minimum curarizing dose of erythroidine was 3 mg/kg., that of dihydroerythroidine, 5 mg/kg. At these dosages the duration of action was 2.5 hours and 4 hours, respectively. As the dose was increased the duration of paralysis increased, the lethal dose of dihydroerythroidine being 60 times the paralyzing dose.

Experiments on cats in which the action potential of the popliteal nerve and toe muscle was recorded showed the complete block of the impulse at the myoneural junction. Recovery from the effects of erythroidine occurred in from 5 to 15 minutes, depending on the dose. Neostigmine (prostigmine) in doses of 0.1 to 0.3 mg. completely abolished the effects of small doses of erythroidine within a few minutes and greatly accelerated the recovery from larger doses. Studies on the antagonism between neostigmine and erythrina alkaloids showed that premedication with the former made the animals more resistant to the latter, while premedication with the latter decreased the toxicity of neostigmine.

Erythroidine proved effective in controlling convulsions induced in dogs by metrazol. Dogs which had two days previously responded to metrazol by severe convulsions were given the same dose intravenously immediately after the injection of 4 mg/kg. of erythroidine. The convulsions were markedly mitigated in some of the dogs, almost completely suppressed in the others. Metrazol did not produce convulsions in dogs administered 6 mg/kg. of erythroidine but respiratory failure occurred in some and this was promptly corrected by 0.5 mg. of neostigmine.

The effects of these alkaloids on the circulation include a transient fall in blood pressure and a slowing of the heart rate. The normal sinus rhythm was unchanged. In dogs anesthetized with sodium-pentobarbital, vagotomy did not prevent bradycardia caused by these alkaloids. Atropine likewise had no effect. In unanesthetized dogs, however, the use of atropine prevented bradycardia.

It is apparent that these two alkaloids have a curare-like action which is directed at the myoneural junction. As with curare the skeletal muscles are paralyzed before the diaphragm and death due to asphyxia follows. Apparently the margin between the dose causing paralysis of the skeletal muscle and that paralyzing the diaphragm is more distinct than it is with curare.

The chief action of the erythrina alkaloids is the blocking of transmission of nerve impulses to the skeletal muscle. Smooth muscles of the gastro-intestinal tract are not affected by erythroidine although salivation, vomiting, defecation and gastro-intestinal distress have been reported by one group of workers.

In potency dihydroerythroidine is as effective as curarine, the most potent alkaloid isolated from curare.

While curare is ineffective when administered orally, both erythroidine and dihydroerythroidine are effective; in fact absorption from the gastro-intestinal tract seems to be as rapid as it is from subcutaneous injection. Unlike curare, these alkaloids are not excreted unaltered in the urine. They are apparently rapidly metabolized after entering the circulation. This may be the reason why curare has a paralyzing action of longer duration than that of erythroidine. The dihydro derivative has a longer action than the latter.

The properties of these erythrina

alkaloids have led to their clinical trial. They have been used with some success in Parkinson's disease but since so few cases have been reported the value of the treatment is still to be established. In the treatment of cerebral palsy these alkaloids were without effect at the dosage used.

It is obvious that not sufficient data are available to allow any accurate conclusion to be drawn concerning the clinical value of erythrina alkaloids. It is to be hoped that further work will be done to establish their position in the therapeutics of spastic condition of skeletal muscles.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Chronic Disease Care

English physicians have begun of late to advocate the treatment in special blocks of general hospitals of patients who had been previously segregated. The most recent of these physicians is Dr. Marjorie W. Warren who, in an interesting article, "Care of the Chronic Sick," in the *British Medical Journal* of Dec. 25, 1943, urges hospitalization of this integrated type for the chronic sick, particularly the aged chronically ill.

Geriatrics, Doctor Warren claims, should be as much a part of the medical student's training as pediatrics, for the steady practice of preventive medicine during the present century has more than doubled the number of those over the age of 60 in England and Wales alone, and this large population has been neglected medically in the various institutions set aside for it. These patients, to be properly cared for, must have the complete diagnostic and therapeutic facilities of a general hospital. If progress is to be made in the diseases peculiar to the aged, research facilities must be made available. Adequate facilities of both types are found only in general hospitals.

Recognizing that elderly people are individualists, Doctor Warren further recommends that the ward set aside for them be small and that day rooms, verandas and occupational therapeutic facilities be provided.—SIGMUND L. FRIEDMAN, M.D.

Fitting Contact Lenses

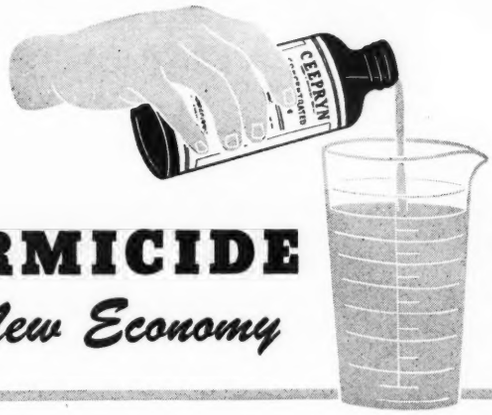
The fitting of contact lenses in the past has been somewhat of a trial and error procedure. While the molded plastic lens is easier to fit than the old type of glass lens, the difficulty has been in knowing what adjustments are necessary in order to fit the individual eye.

Philip L. Salvatori and Americo Oriani, in an article, "The Fitting of Contact Lenses," in the December 1943 issue of *Archives of Ophthalmology*, state that they have formulated simple rules that may be applied to the fitting of lenses in all cases. These rules eliminate guesswork and give assurance that the lenses will be fitted correctly and skillfully.

In the fitting of contact lenses the following factors must be considered: (1) convergence of the eyes, (2) pressure of the lids and (3) gravity drop.

To compensate for these factors, the lens is fitted so that the corneal portion is decentered upward and turned slightly nasally. A perfectly fitting lens rests evenly on the eyeball. No tight areas should appear in any movement of the eye, and there should be no loose areas. In fitting the incompletely finished lens, the following important steps must be observed:

1. The lens is checked for over-all size.
2. It is checked for rotation.



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3. The fluorescein dye test is applied to detect either loose or tight areas.
4. The corneal center of the lens is marked.
5. A working diagram is made.

Tight areas that are detected are eliminated before the loose areas are adjusted. In many instances, after the tight areas are corrected, the loose areas disappear. Those which remain are then adjusted.

The writers describe in detail the procedures to be observed in the fitting and adjusting of lenses and they enumerate the required steps that must be taken in order to perform each procedure effectively and properly. Apparatus, instruments and technic are described in a concise and lucid manner. This article should be of value to all of those who are engaged in the fitting of contact lenses.—EDWARD KIRSCH, M.D.

War Neurology

In a recent review of the contributions to war neurology, in the *American Journal of Medical Sciences,* January 1944, Dr. A. J. Lubin divided his subject into (1) head injuries, (2) peripheral nerve injuries, (3) meningococcic meningitis (which has recently risen to epidemic proportions in both military and civilian life) and (4) the use of the electroencephalograph as related to war.

Traumatic disorders of the head can be divided into two general groups: (a) closed injuries, which include all trauma without direct penetration of the dura, and (b) open injuries. Those injuries with direct penetration of the dura are further subdivided into (a) gutter wounds in which the missile has made a furrow through the scalp and caused fragments of bone, hair and clothing to penetrate into the brain; (b) simple penetrating wounds which also carry débris into the brain; (c) penetrating wounds from multiple, usually small, fragments; (d) perforating injuries with débris scattered along the track, and (e) injuries involving the air sinuses.

The mortality rate of 60 per cent in cases of head injury during the early stages of World War I has been reduced to probably less than 30 per cent in the present war. This drastic reduction has been made possible by the employment of the sulfonamides.

Interestingly, it has been found that prolonged disability following head injuries is due more often to psychoneurotic symptoms than to organic defects.

Injuries to peripheral nerves are an important problem in war medicine; these injuries are frequently associated with compound fractures or with wounds that were not sufficiently healed to allow an anastomosis. Peripheral nerve injuries have been recently reclassified as follows: (a) complete anatomic division of the nerve (prompt surgical intervention is indicated in this wound); (b) complete loss of function without anatomic disturbance of the internal structure of the nerve (in this group regeneration occurs more rapidly and more completely than in group 1); (c) transient block (this group is characterized by partial loss of function, which is mainly motor in character, and relatively rapid recovery of function without surgery).

In a review of the health of the U. S. Army, it has recently been stated that the Army has experienced an outbreak of meningitis which is similar to, though milder than, that which occurred in World War I. The incidence in the civilian population has increased five-fold over the previous five year average. The case fatality rate has, however, decreased from 34 per cent in World War I to somewhere between 3 and 5 per cent; this decrease is due chiefly to the use of sulfonamides.

The usefulness of electroencephalographic examination of military personnel is said to fall into three main categories: (a) examination of applicants for service, the examination being

confined to those men with histories of fainting attacks or head injuries; (b) examination of men actually in the service who have fainted or have had convulsive seizures, and (c) determination of the extent of intracranial damage to members of the personnel who have suffered head injuries.—SIGMUND L. FRIEDMAN, M.D.

Electric Blankets

The authors, G. Malcolm Brown and K. Mendelssohn, who had previously participated in a study on the action of radiant heat cradles, carried out an investigation on the action of electric blankets, which was reported in the *British Medical Journal,* March 18, 1944.

Using a large heating pad 33 by 46 inches, with a consumption of about 120 watts, they found that the current passing through the blanket was 0.511 amp. at the outset and 0.517 after four hours. The total amount of heat produced by the blanket was about 100 kilogram calories per hour.

The electric blanket was covered with a woolen blanket, heated for two hours, and the patient was then placed on top of this. Another woolen blanket was used to cover the patient. The treatment lasted from one and one half to two hours. To determine the body temperature, oral thermometers were used in some cases and rectal thermometers in others.

The first reaction to the application of heat, by means of either the radiant heat cradle or the electric blanket, was a decrease in body temperature. When the cradle was used the temperature drop occurred at from five to twenty minutes after the treatment commenced. When the blanket was used the drop occurred from 30 to 90 minutes after the heat was first applied. The authors say that the electric blanket has advantages that recommend it for certain clinical uses. It is safe and causes no discomfort at ordinary heating rates. It requires a little supervision. The risk of burns is less than with an unshielded cradle.

An important disadvantage, the authors point out, is the long period taken to reach the maximum temperature. Even when the bed is warmed beforehand, it is only half as quick as the radiant heat cradle in raising the body temperature.—JOHN F. CRANE.

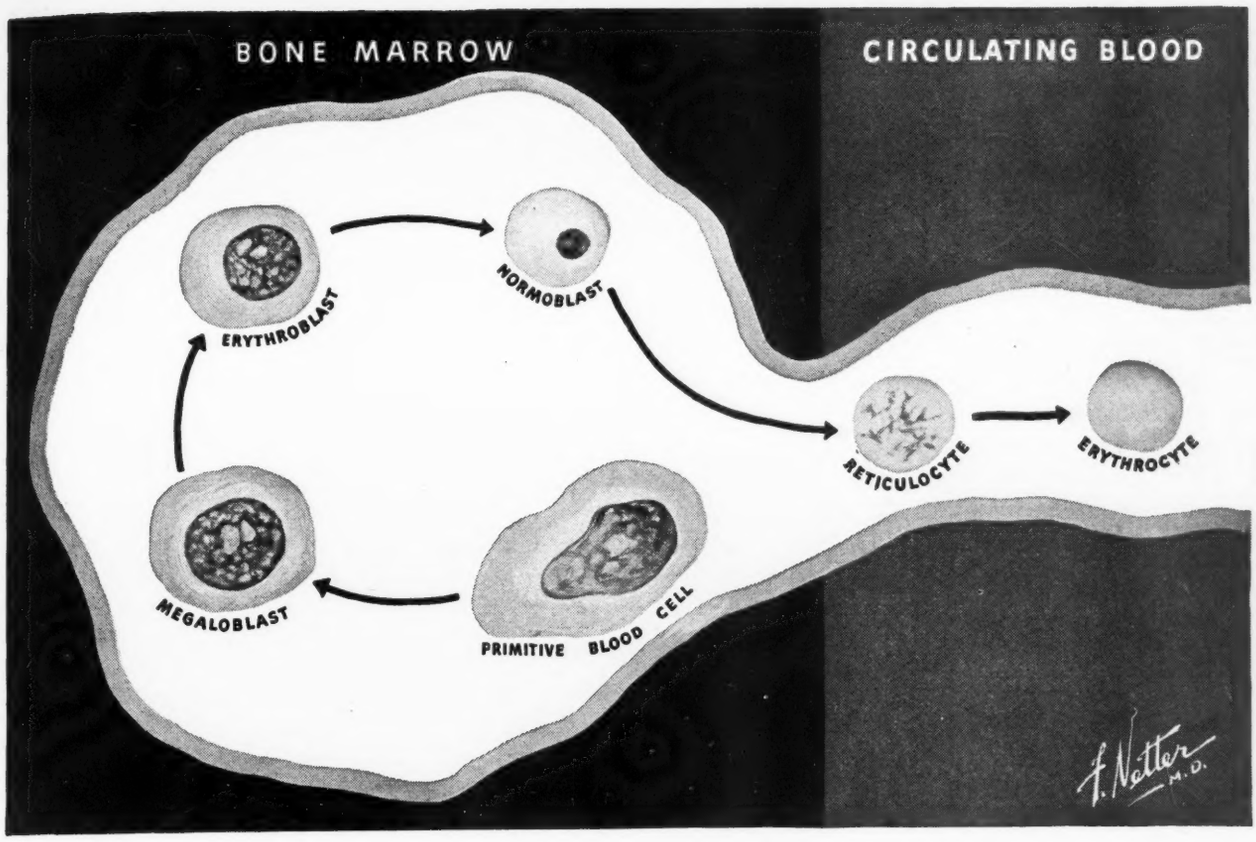
Cadaver Plasma

The report by Lowel H. Erf entitled "A Note Recommending the Use of Dried Plasma Obtained From Fresh Cadaver Blood" in the *American Journal of Medical Science,* March 1944, deals with a case in which the plasma of a recently deceased cadaver was administered to a patient with a malignant disease.

Sterile saline was forced into the arterial system through cannulae in the brachial artery and vein, and a mixture of blood and saline was withdrawn. The vein cannula was connected with partially vacuous transfusion bottles. Some of these flasks contained sodium citrate. After centrifugation the plasma was cultured, frozen in glass ampules, dried and recultured. The serum of the remaining quantity of fluid was treated in the same manner.

The yield from 4 pints of cadaver blood mixed with saline produced 30.5 gm. of dried plasma and 14 gm. of dried serum. The plasma was then restored to one fourth of the original volume with distilled water and administered intravenously. Microscopic examination of the organs of the recipient six to seven weeks after the administration of the cadaver plasma and serum revealed no changes attributable to the injection.

The administration of sterile dried cadaver plasma may be, in part, a practical solution to the problem of the blood plasma need during the war-time emergency. The author points out the availability of large quantities of cadaver blood for dried plasma and likewise defends the use of this material.—MICHAEL LEVINE.



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FOOD SERVICE

Pay Cafeteria "Pays"

E. J. KRAHENBUHL
Comptroller
Hospital of St. Barnabas and
for Women and Children, Newark, N. J.

M. H. O'HORA
Chief Dietitian
Hospital of St. Barnabas and
for Women and Children, Newark, N. J.

IN NOVEMBER 1943 after consideration over a period of a year or more, the Hospital of St. Barnabas and for Women and Children, Newark, N. J., adopted the pay cafeteria plan of food service for its personnel. Until that time it had operated two dining rooms, one for nurses, technical and other professional employes and the other for domestic help. No charges, of course, were made under this arrangement, each employe procuring his meals in accordance with the terms of his employment.

Although for a number of years we had been sympathetic to the accepted plan, followed by business in general, of compensating employes in one common denominator, namely, cash, thereby permitting them to purchase personal requirements, such as food, lodging and laundry service, in whatever quality they chose, we, like many other hospitals, hesitated to make the necessary changes.

However, certain conditions arose that made such changes definitely desirable. For example, from the laundry department where the personnel is in a comparatively low wage bracket came constant pressure for increases in wages. We met this pressure in the usual way, by comparing our rates with those of other hospitals and other commercial laundries in the vicinity. In these comparisons, which were duly presented to the laundry employes, we included as part of the compensation a fair amount for the value of the meals to which they were entitled.

No amount of explanation, however, would convince the employes that the meals they were receiving were of the value that we had stated. They wanted cash and preferred to bring their own lunches. Many of them claimed that they did not take three meals because they lived near the hospital and felt obliged to have some of their meals with their families at home. This was in a measure true. So the matter was finally settled by agreeing to give these employes a cash remuneration instead of meals.

Similar situations developed in the houskeeping, plant, maintenance and other departments, all of which were adjusted about the same way. Also, many nurses, who were living at home, requested cash instead of meals.

These conditions prompted us to make the change and convert our one large dining room into a pay cafeteria. All employes' salaries were adjusted on the following basis: Breakfasts were valued at $1.50 a week, dinners at $3 a week, suppers at $2.10 a week. To illustrate, an employe entitled to three meals a day received $6.60 per week additional in his pay check.

Red Cross dietitian's aide aids the cashier in checking trays.

Patrons have their change ready before reaching cashier.

A corner of the cafeteria that was made from a dining room.

These values were determined by keeping an accurate record, over a considerable period of time, of the total cost of food consumed in each meal and dividing this total cost by the number of persons served. To these resulting figures we added 100 per cent mark-up to cover the cost of pay rolls, supplies, depreciation and overhead. This, then, represented what we calculated it was costing us for the average meal, separately for breakfast, dinner and supper.

In converting to the pay cafeteria plan certain physical changes in the main dining room had to be made and new articles of equipment were

Counter girls are instructed in how to serve portions.

View of the napkin, tray, glass and silver section.

purchased. We had a modest advantage in that, when the dining room was originally planned, there was installed a small self-service counter, which had been used for breakfast. This was added to considerably by purchasing an additional ice bain-marie refrigerator, ice cream freezing cabinet and toaster.

Other purchases included an electric grill, cream dispenser, cash register and additional trays, flat silver, serving implements for standardization of portions, napkin and glass dispensers. The total cost of conversion was approximately $2000.

The cafeteria operates on the four meal a day plan. Meal hours are as follows: breakfast: 6:30 a.m. to 9 a.m.; dinner: 12 noon to 1:30 p.m.; supper: 5 p.m. to 6:20 p.m.; midnight meal: 11:30 p.m. to 12:30 a.m. All employes, regardless of classification, are permitted to patronize the cafeteria. In addition to the main course, a choice of sandwiches, salads and desserts is offered. Also, at breakfast, a choice of fruit, cereal and eggs or a choice of eggs and meat course is provided. A reasonable variety of food is served. Following is a typical dinner menu.

Cream of lettuce and almond soup
Grilled cube steak
French fried potatoes Fresh green peas
Corn relish
Sliced beets and celery on chicory
Choice:
Smithfield ham and tomato sandwich on rye bread
Chopped egg and olive sandwich on wholewheat bread
Bread (all varieties), butter
Molded prune whip with custard sauce
Angel food cake
Strawberry ice cream
Coffee Tea
Milk, chocolate or buttermilk

Each article of food is priced separately. The prices are posted on a menu board at the entrance of the cafeteria and also behind the cafeteria counter. In calculating the price to be charged, the cost of ingredients for each article is determined and, generally, is marked up 100 per cent to cover the cost of pay rolls and supplies. This calculation is done on a card, which is filed for future reference, and unless there has been a marked variation in the purchase price that same price as indicated on the card is charged when that article of food is served again.

Each patron procures a tray and selects his silver and napkin at the entrance to the cafeteria line. The articles of food are then selected and at the end of the line the cashier "reads" the tray and registers the amount collected on the cash register. At the close of each meal the cash is balanced with the cash register tape and forwarded to the main hospital cashier. Approximately 500 meals are served each day.

The cafeteria personnel consists of the following: one assistant dietitian in charge, five counter girls, one runner, three bus girls, two dishwashers, one cashier and counter supervisor. The total receipts are approximately $58,000 a year.

While there was no reduction in personnel arising out of the change, several conditions developed that precluded this. Because of the extreme shortage of personnel in this area, which is heavily engaged in war work, we were obliged, in order to get any help at all, to change the hours from the split-time arrangement to the straight eight hours per day. This change was made at about the same time that we adopted the pay cafeteria plan. Furthermore, the efficiency of the personnel that we are able to employ, even with this improvement in working hours, is far less than was the case previously.

It is our considered judgment that the cafeteria plan *versus* the waitress service plan, on a comparable basis, would save at least three employes. While this saving is considerable, it is not, to our way of thinking, the most important consideration. Far more important is the saving of food waste, for individuals who pay out their hard-earned cash are extremely careful in what they select and are not wasteful when their pocketbooks are affected.

Our experience in this respect prior to the installation of the pay cafeteria was an abnormally high food waste. Many of our employes would take the complete course whether or not they could eat it, feeling that they were entitled to the whole meal. Then, too, if the meal did not suit the individual's taste, it was taken anyway and spoiled. The natural result of this condition was to stimulate employe grievances.

In conclusion, the merits of the pay cafeteria are evident in the economies produced and in the improved relationship with personnel.

Let's Eat Without Emotion

An anthropologist and a pediatrician agree that eating should be divorced from emotion in the interests of better national health

IF EATING and emotions can be divorced, the public may live happily ever afterward. But, to accomplish this, divorce proceedings must be started on the day of birth.

Two rather picturesque papers presented to midwestern dietitians and medical social workers meeting in joint conference at the Tri-State Hospital Assembly in Chicago on May 10 seemed to add up to some such conclusion as the one stated above.

From Washington came the anthropologist, Dr. Margaret Mead, and from the University of Chicago by way of Johns Hopkins came the pediatrician, Dr. Parker Dooley, with suggestions and early research on ridding the sick and the well of emotional attitudes toward food.

No Dessert for Junior

"We live in a reward and punishment society," Doctor Mead told her large audience. "Take dessert out of the American diet and parents wouldn't know how to bring up their children. So from early life highly organized emotional attitudes toward food are developed.

"In our hospitals we chop patients and we chop the family up. The next job is to get the patient back into a unit and then to get the patient back into the family so it is a unit.

"Until recently it has never occurred to the hospital to integrate the dietitian into the conferences of the doctors and social workers. Without such cooperation the patient's personality steadily disintegrates. Without any concise method of referral, the psychiatrist or physician sends a patient to the dietitian and says, 'This patient needs to lose weight.'

"An interview with a dietitian that lasts for ten minutes or an hour in which the patient is told to give up certain gratifications in diet and substitute some foods he doesn't like has potentialities for therapy that are good or bad. The dietitian's instructions, to be effective, must be in accord with the patient's personality. A really good dietitian can make a diet look as big as a mountain or as small as a mouse. Her success in the past has come because she has grasped inexplicitly or inarticulately the emotional background of the patient."

The project with which Doctor Mead is now connected, on loan from her work at the Natural History Museum in New York, is a joint effort on the part of the American Dietetic Association and the National Research Council to fit the dietetic interview in with the other types of interviews that form a part of the patient's therapy.

Doctor Mead regards the medical social worker as the natural bridge between the psychiatrist and the dietitian. The real problem is, of course, that the psychiatrist and social worker know little about dietetics and the dietitian knows little about psychiatry and medical social work.

So far in the A.D.A.-National Research Council study, 14 case histories are available for discussion, representing the contributions of psychiatrist, medical social worker and dietitian in solving the patients' problems. Mimeographed copies of this beginning research are available in groups of threes, so that each of the groups concerned can be educated simultaneously.

Asked how dietitians are to get a grasp of medical social work and understanding of emotional attitudes and how social workers and doctors are to get a small working knowledge of nutrition, Doctor Mead declared that in her opinion there is no room in professional training for these subjects and that they must become prerequisites to professional courses, thus affording a broader base before the student begins to specialize.

And now to Doctor Dooley and his work with infants and their mothers. The ideal of the pediatrician in regard to nutrition is for the child to eat without thought, digest without thought and defecate without thought, just as he breathes, sees and hears without thought.

Either every child patient the pediatrician sees has a nutritional deficiency or his parents think he has a nutritional deficiency. In the past the patient has been referred to the dietitian, who was to give him a high vitamin diet or a high calcium diet and to make him eat it and like it. The sensitive dietitian has been baffled by the problem of making a child eat and like certain healthful foods.

The plan of Doctor Dooley and his associates at the University of Chicago Clinics is to talk to the mothers in groups before they leave the hospital with their new babies. Some 16,000 group interviews have been held. They are compounded of grandmotherly advice and a few radical ideas. They proceed something like this.

Every Baby Is Different

"Your baby is perhaps quite different from every other baby. We believe it is an anthropologic truism that people are more different on the day they are born than they are at any other time. Maybe nobody knows how much this particular baby of yours ought to eat. Some babies consume a lot of breast milk; others take only a little. Why not let the baby decide what he wants to eat when he asks for it. Maybe he should eat at three hour intervals, maybe at five. The four hour schedule at the hospital is for our convenience not for his particular interest.

"Now what shall you feed the baby? It is wise to give him breast milk if you can. If you cannot, don't fret. When a child is six

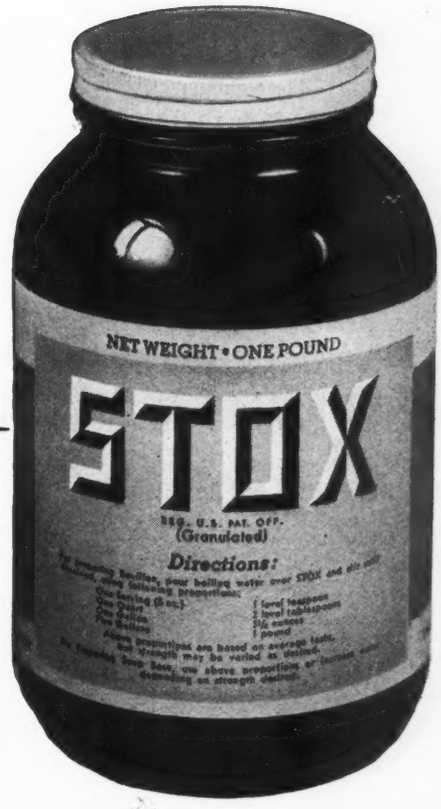
Do *you* know this new product?

STOX

GRANULATED BOUILLON

Gives quantity cooked foods that wanted "home quality" flavor

Rich in Vitamin B_1



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STOX fits a dietitian's needs *exactly*.

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With Stox you can add a meaty taste to meatless dishes—plus extra vitamin values. A yeast-vegetable product, Stox is a source of B-complex vitamins—especially Vitamin B_1. One cup of Stox Bouillon, or one level teaspoon of Stox, supplies ¼ of the minimum daily adult B_1 requirements.

Write Stox down on your supply order today. Stox cost per serving is low. Stox improvement in the flavor and food value of a dish is high.

Make delicious STOX bouillon like this:

1 level teaspoon Stox + 1 cupful boiling water = 1 cup delicious bouillon

Stir—for a cheering, satisfying drink. The *granulated* form makes Stox dissolve almost instantly—saves your time. Makes it easier to adjust the strength, too.

Serve popular STOX dishes like these:

Add Stox to stews, meat dishes, leftovers, aspics. Stox gives a "home quality" flavor, adds extra nutritive value to every dish you use it in. Helps you make use of foods that might be wasted, too. Use Stox in gravies, to build up meat stock, to stretch soup, to replace the stock pot.

STOX is quick, economical, clean in handling. No refrigeration needed. Keep in cool, dry place with lid on tight and there will be no loss or waste.

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months old, no pediatrician can tell whether he has been breast fed or bottle fed from the appearance and development.

"There is a psychological advantage in breast feeding, however, for the infant is more likely to feel at home and safe in the transfer from the warm aquatic life before birth to a cold dry world. Yet some mothers antagonize their infants during breast feeding by not holding them right."

The "line" that these Chicago pediatricians are giving new mothers is expected to bear its fruit some years later. It can be used, if it appears to work out successfully, by the nurse, the dietitian and the medical social worker.

Doctor Dooley's conclusion was that the dietitian belongs also in the well baby clinic and the nursery "where her stuff sticks." It is merely an amplification of the work the dietitian has to do in the neonatal clinic. Such good nutritional habits as she can help develop there mean that her services will be less needed in therapy farther along.

Paper Dishes: a War Fatality

Having experimented successfully with paper dishes and found them an answer to the manpower problem, certain dietitians are back where they were before. The paper shortage is making it difficult to get any variety of types and sizes.

During the poliomyelitis epidemic in Chicago last August and September, Margaret Cowden, director of dietetics, Michael Reese Hospital, Chicago, used paper dishes exclusively for patients suffering with this disease, with the result that both time and labor were saved. Since that time, owing to the paper shortage, she has had to give up the use of paper dishes except for isolated patients. At present only two sizes of plates and cups for both hot and cold liquids are available. Dessert dishes and supper dishes are out for the duration.

Miss Cowden found that comments from patients were usually favorable but as most of them were children they were not critical. The disadvantages, as she sees them, are: (1) they do not retain heat; (2) unless a hard finished dish is used, it absorbs liquids, looks badly and has an odor of wet paper; (3) they take more storage space than china. On the other hand, several advantages were noted: (1) they eliminate labor, (2) are light and easy to handle and (3) facilitate disposal of dishes from isolated patients.

FOOD FOR THOUGHT

Give Patients What They Want

If a 68 year old patient asks every day for three weeks for coffee cake for breakfast and still leaves the hospital without having had anything except toast, he isn't going to be a booster for hospitalization.

Nell Clausen, president of the American Dietetic Association, thinks such incidents as the foregoing are bad hospital public relations. Even if the old man was on a diet precluding coffee cake, he should have had a little since his heart was set on it.

"'Anything to get patients to start eating' is our motto at Milwaukee Children's Hospital," Miss Clausen told fellow dietitians at the Tri-State Hospital Association's luncheon for dietitians on May 11.

When hospitals can get and will employ more dietitians so that closer contacts can be made with patients a better selling job can be done on hospital

The Best All-around Mixer in Food and Drink Circles . . .

1-2-3 MIXER*

. . . and just like its name . . . so simple . . . so practical . . . the first numbers in tart flavoring for all food and drink . . . 1-2-3 mixes for the experts —the chef, the baker, the dietitian, the fountaineer, the commissary man . . . 1-2-3 Mixer does an amazing all-around job.

Saves valuable time . . . no mess . . . no waste . . . every drop is utilized . . . consistency that imparts a uniform tartness and smooth flavor to all parts of the food and drink . . . "wherever, whenever a Tart Flavor or Sour Base is Desired". Let us show you how it has proved itself!

* Made with the natural oils of California lemons (or West Indies Limes or California Oranges). Contains no artificial preservatives. In its packaged form 1-2-3 Mixer will last indefinitely. Endorsed by the American Institute of Food Products.

FREE: For a Sample Quart of 1-2-3 MIXER, call or write any authorized distributor or —

CAUTION: Beware of imitations 1-2-3 Mixer is the original 2-bottle package, necks protruding from package. Look for the patent No. 1,731,153 to make sure you are getting the original — the assurance of the right quality.

In Lemon Pies, Cakes, Cookies; Meat and Fish Sauces, Dressings, Desserts, delightful "Coolers" and superb Sherbets (the latter in all 3 flavors). **Ask for FREE RECIPE FOLDER.**

One Two Three Company Inc.

CHICAGO — 150 VARICK STREET NEW YORK 13 — LOS ANGELES

food, this nutritionist believes, and complaints about food, particularly food that isn't hot, are the commonest charges leveled against hospital service.

Keeping Employes Interested

Some applied psychology in the hospital kitchen will help to reduce labor turnover, Nell Clausen of Milwaukee Children's Hospital believes.

The passing on to kitchen employes of any praise or compliments received from patients, guests or the administration is one step in this direction.

At Milwaukee Children's new employes are taken on a tour of the entire hospital so that they will quickly come to feel that they are a part—a significant part—of the institution. Reports of weight gains made by the children are relayed to the kitchen so that employes may feel a sense of accomplishment. They even know a little about striking individual cases.

Recently, a little girl with a bad case of eczema was put in a wheel chair and brought to the kitchen where the employes could see the severity of her condition. They had known of her presence in the hospital for a different food was being sent to her each day in an effort to find the offending substance or substances causing the disorder. Now these daily food changes that go up to Elsa have brought some "professional" excitement in the kitchen and no doubt some weeks later Elsa's recovery will be reported either by word of mouth or a return visit.

Dietitian Shortage

Some idea of the dietitian shortage confronting hospitals today is given by Gladys E. Hall, executive secretary of the American Dietetic Association.

From a membership of 6000, the A.D.A. has had 3500 changes of address. Two thirds of these changes are among hospital dietitians, one out of four of whom has left the hospital field for the Army. Others have gone into industry, state and county health departments and service agencies, such as the Red Cross.

Out of 452 jobs open on May 9 as reported to the A.D.A., 86 per cent are hospital jobs. To fill these there are only 106 active registrants, most of whom want a special type of position or one certain location only. Some of these, too, are without experience. In contrast with the present situation, ten years ago, the A.D.A. had seven openings on its list and 368 registrants.

RECIPES BY REQUEST

Prune Honey Pie

2½ cups uncooked prunes
1 small unpeeled lemon
1 cup water
½ cup honey
2 tbsp. butter
½ tsp. salt
1 tbsp. cornstarch
1 tbsp. cold water
Pastry for bottom crust and strip-top

Boil prunes ten minutes in water to cover, drain and cut from pits. Slice lemon, remove seeds and put through food chopper, using medium knife; combine with prunes, water, honey, butter, salt and cornstarch which has been moistened in the cold water. Pour into a pastry-lined pie pan (9 inch) and cover with pastry strips. Bake in hot oven (450° F.) twenty-five to thirty minutes.

Prune Flip

1 cup sweetened prune pulp
3 cups chilled milk
Whipped cream

Beat milk into prune pulp with rotary beater or shake in shaker. Pour into glasses and top with whipped cream. For variety add few gratings of lemon or orange rind.

In the Dietary Adjustment

DEMANDED BY FEBRILE DISEASE

During periods of acute febrile disease, dietary adjustment must be made to satisfy the change in nutritional demands. Protein requirements are increased 50 to 100 per cent, caloric expenditure is raised because of increased heat loss, and vitamin needs, especially those of the water-soluble groups, are greater. Only by fully meeting these altered requirements can recovery be hastened, can convalescence be shortened, and the usual state of lethargy reduced in severity.

Designed to supplement the diet during periods of increased metabolic activity, Ovaltine is a powerful weapon in preventing nutritional insufficiency during these periods. The abundantly supplied nutrients of this palatable food drink are quickly assimilated and metabolized. Its delicious taste makes it appealing even to the seriously ill patient who usually presents a feeding problem. Because Ovaltine greatly reduces the curd tension of the milk in which it is dissolved, it leaves the stomach promptly, rarely produces nausea or anorexia, presents no undue digestive burden.

THE WANDER COMPANY, 360 NORTH MICHIGAN AVENUE, CHICAGO 1, ILLINOIS

Ovaltine

Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

Menus for July 1944

Mrs. T. David Bass
St. Mary's Hospital
Green Bay, Wis.

Recipes will be supplied by The Modern Hospital, Chicago

1
Sliced Oranges
Soft Boiled Eggs
•
Vegetable Soup
Swiss Steak
Parsley Buttered Potatoes
Spinach With Bacon
Waldorf Salad
Heavenly Rice
•
Cream of Celery Soup
Hamburgers and Buns
Stuffed Baked Potatoes
Spiced Beet Salad
Mixed Fruit

2
Melon
Bacon
•
Chicken-Rice Soup
Baked Chicken
Mashed Potatoes
Buttered Green Beans
Pear and Cheese Salad
Chocolate Sundae
•
Consommé
Tomato Stuffed With
Tuna Salad
Potato Chips
Head Lettuce, Thousand
Island Dressing
Marble Cake

3
Stewed Prunes
Shirred Eggs
•
Minestrone
Lamb Chops
Creamed Potatoes
Glazed Carrots
Fruit Salad
Washington Cream Cake
•
Tomato Juice
English Beef Stew
Dumplings
Head Lettuce, Russian
Dressing
Sliced Peaches
Cookies

4
Blueberries
Omelet
•
Noodle Soup
Boned Perch
Escalloped Potatoes
Buttered Peas
Butterfly Salad
Lemon Pie
•
Potato Soup
Creamed Asparagus on
Toast
Baked Potatoes
Vegetable Salad
Ice Box Cake

5
Bananas
Bacon
•
Tomato Soup
Pot Roast
Browned Potatoes
Cauliflower au Gratin
Rosy Pear Salad
Prune Whip
•
Corn Chowder
Chop Suey
Buttered Rice
Mixed Vegetables
Gelatin Salad
Fruit Compote

6
Oranges
Scrambled Eggs With
Bacon
•
Barley Soup
Veal Cutlets
Mashed Potatoes
Spinach With Hard Boiled
Egg
Fresh Green Salad
Raspberry Sherbet
•
Cream of Chicken Soup
Sandwich Loaf
Potato Salad
Sliced Tomatoes
Chocolate Cake

7
Pears
Poached Eggs
•
Vegetable Soup
Fillet of Sole
Parsley Buttered Potatoes
Buttered Green Beans
Chef's Salad
Strawberry Shortcake,
Whipped Cream
•
Asparagus Soup
Shrimp à la King
Buttered Noodles
Orange-Avocado Salad
Pineapple Ice

8
Stewed Figs
Bacon
•
V-8 Cocktail
Roast Beef
Minted Mashed Potatoes
Summer Squash
Deviled Egg Salad
Blueberry Roll, Whipped
Cream
•
Broth
Meat Loaf, Tomato Sauce
Baked Potatoes
Cottage Cheese Salad
Whipped Gelatin

9
Applesauce
Canadian Bacon
•
Chicken Noodle Soup
Baked Chicken
Riced Potatoes
Peas and Carrots
Cabbage-Apple Salad
Caramel Sundae
•
Pear Juice
Assorted Cold Cuts
Fresh Fruit Salad
Stuffed Celery
Applesauce Gingerbread,
Whipped Cream

10
Melon
Soft Boiled Eggs
•
Pineapple Juice
Liver and Bacon
Creamed Potatoes
Broiled Tomatoes
Head Lettuce, Snappy
Dressing
Chocolate Eclairs
•
Celery Soup
Lamb Boats
Lyonnaise Potatoes
Tossed Salad
Jelly Roll

11
Stewed Prunes
Scrambled Eggs
•
Pea Soup
Baked White Fish
Golden Mashed Potatoes
Broccoli
Peach-Nut Salad
Vanilla Ice Cream
•
Tomato Juice
Creamed Cheese and
Mushrooms on Toast
Buttered Beets
Melon Salad
Custard

12
Green Grapes
Bacon
•
Vegetable Soup
Veal Roast
Hashed Brown Potatoes
Corn Creole
Combination Salad
Boston Cream Pie
•
Spinach Soup
Chicken à la King
Buttered Rice
Gelatin Salad
Pineapple
Cookies

13
Baked Apples
Shirred Eggs
•
Grapefruit Juice
Steak
Mashed Potatoes
Creamed Carrots
Pear-Grape Salad
Upside-Down Cake
•
Barley Soup
Cold Sliced Ham
Baked Potatoes
Olives and Radish Roses
Bread Pudding, Caramel
Sauce

14
Orange Slices
Poached Eggs
•
Clam Chowder
Baked Salmon
Potato Cakes
Buttered Wax Beans
Asparagus Tip Salad
Chocolate Roll, Whipped
Cream
•
Tomato Bouillon
Grilled Cheese Sandwich
Lattice Potatoes
Spring Salad
Peaches
Cookies

15
Rhubarb
Canadian Bacon
•
Bean Soup
Lamb Chops
Au Gratin Potatoes
Harvard Beets
Head Lettuce, Fruit
Dressing
Orange Ice
•
Mixed Fruit Juice
Meat Balls
Spanish Rice
Stuffed Tomato Salad
Fruit Gelatin

16
Strawberries
Bacon
•
Fruit Cup
Fried Chicken
Mashed Potatoes
Broccoli, Hollandaise
Sauce
Chef's Salad
Vanilla Ice Cream
•
Vegetable Soup
Tuna Salad
Potato Chips
Cabbage Slaw
White Cake

17
Cinnamon Applesauce
Scrambled Eggs
•
Cream of Mushroom Soup
Roast Beef
Browned Potatoes
Corn on the Cob
Melon Salad
Bavarian Cream
•
Consommé
Meat Pie
Buttered Peas
Stuffed Celery
Fruit Cup
Cookies

18
Bananas
Bacon
•
Pineapple Juice
Baked White Fish
Creamed Parlsey Potatoes
Buttered Asparagus
Peach-Nut Salad
Applesauce Flip
•
Cream of Carrot Soup
Cheese Fondue
Baked Potatoes
Head Lettuce, Thousand
Island Dressing
Grapefruit and Pineapple
Cookies

19
Raspberries
Soft Boiled Eggs
•
Pineapple Juice
Veal Chops
Mashed Potatoes
Glazed Parsnips
Tomato-Cheese Salad
Cranberry Ice
•
Rice Soup
Cold Sliced Ham and
Chicken
Baked Noodles
Combination Salad
Cherries, Cookies

20
Orange Slices
Canadian Bacon
•
Potato Soup
Swiss Steak
Escalloped Potatoes
Buttered Broccoli
Fruit Salad
Prune Pie, Whipped Cream
•
Pear Juice
Hamburger Casserole
Mixed Vegetables
Banana-Date Salad
Marble Cake

21
Blueberries
Poached Eggs
•
Fruit Cup
Fried Scallops
Creamed Potatoes
Peas and Carrots
Tossed Green Salad
Ice Box Cake
•
Tomato Consommé
Spanish Omelet
Baked Potatoes
Pineapple-Cheese Salad
Tapioca Pudding

22
Stewed Prunes
Bacon
•
Oxtail Soup
Rolled Rib of Beef
Browned Potatoes
Harvard Beets
Olives and Stuffed Celery
Prune Whip
•
Grape Juice
Ribbon Sandwiches
Potato Chips
Melon Salad
Bread Pudding, Caramel
Sauce

23
Rhubarb
Scrambled Eggs and Ham
•
Chicken Noodle Soup
Baked Chicken
Mashed Potatoes
Brussels Sprouts
Tomato Salad
Chocolate Sundae
•
Celery Soup
Cold Sliced Tongue
Egg Salad
Head Lettuce, Fruit
Dressing
Fruit Cup, Cookies

24
Grapefruit
Canadian Bacon
•
Leek Soup
Breaded Veal Cutlets
Parsley Buttered Potatoes
Summer Squash
Pear Porcupine Salad
Banana Cream Pie
•
Pineapple Juice
Escalloped Ham and
Potatoes
Buttered Spinach
Orange Basket Salad
Rice Pudding

25
Orange Slices
Omelet
•
Tomato Juice
Baked Bass
Lyonnaise Potatoes
Corn Creole
Cheese Coleslaw
Strawberry Shortcake,
Whipped Cream
•
Vegetable Soup
Swedish Soufflé
Mashed Potatoes
Chef's Salad
Apricots, Cookies

26
Raspberries
Bacon
•
Jellied Bouillon
Broiled Steak
Riced Potatoes
Buttered Wax Beans
Cinnamon Apple Salad
Banana Cream Pie
•
Barley Soup
Assorted Cold Cuts
Macaroni Salad
Spiced Beets
Cottage Pudding,
Chocolate Sauce

27
Strawberries
Scrambled Eggs
•
Pea Soup
Veal Roast
Creamed Potatoes
Glazed Carrots
Head Lettuce, Thousand
Island Dressing
Blueberry Pie
•
Grapefruit Juice
Italian Spaghetti
Mixed Vegetables
Fruit Salad
Custard

28
Melon
Poached Eggs
•
V-8 Cocktail
Baked White Fish
Au Gratin Potatoes
Buttered Peas
Golden Salad
Chocolate Roll, Whipped
Cream
•
Rice Soup
Shrimp à la Newburg
Stuffed Baked Potatoes
Tossed Salad
Lemon Snow

29
Grapefruit
Canadian Bacon
•
Vegetable Soup
Lamb Chops
Parsley Potatoes
Peas and Turnips
Avocado Salad
Strawberry Pie
•
Cold Ham
Stuffed Baked Tomatoes
Spring Salad
Custard, White Cake

30
Green Grapes
Bacon
•
Noodle Soup
Fried Chicken
Mashed Potatoes
Cauliflower au Gratin
Gelatin Salad
Fresh Peach Sundae
•
Tomato Juice
Chow Mein
Buttered Rice
Vegetable Salad
Pears

31 Blueberries, Omelet • Fruit Cup, Roast Beef, Browned Potatoes, Buttered Asparagus, Gelatin Salad, Frozen Custard • Spinach Soup, Ham Salad Sandwiches, Lattice Potatoes, May Fruit Salad, Marble Cake

"and, Lulu, they even serve Ry-Krisp!"

Doctors recommend it... patients love it
Is Ry-Krisp served in *your* hospital?

Watch them beam when you serve them Ry-Krisp! This deliciously different bread hits the spot because it has all the fresh whole rye flavor with an especially appealing crisp-toasted texture. Probably the only 100% whole grain bread available nationally.

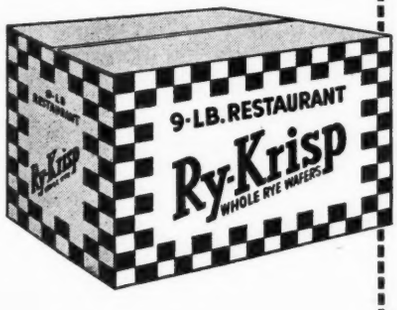
Economical! Four wafers cost only one penny. No loss from staleness... Ry-Krisp comes packed in wax-wrapped trays.

HOSPITAL DIETITIANS RECOMMEND RY-KRISP

In Low-Calorie Diets because it has only 23 calories per slice yet furnishes the minerals and almost all the vitamin B_1 of whole rye, provides bulk to aid regularity.

In Allergy Diets because it does *not* contain wheat, eggs or milk—the three main offenders; a safe bread made simply of whole rye, salt and water.

Low-Calorie and Allergy Diets Free on Request



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Please send, no cost or obligation, new wartime low-calorie diets; also wheat, milk, egg-free diets and recipes.

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*Address*_____

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CONDUCTED BY W. W. DAVISON

Keep Motor Starters Clean

THE proper maintenance of motor starters not only is essential to starter life but, since it also protects the motor against burn outs from overloads and low voltage, is essential to proper motor performance and life.

Satisfactory maintenance requires competent men and an adequate plan of handling inspection and repair so as to avoid high maintenance costs, replacements, lost time.

Preventive maintenance begins with the proper selection of the motor starter. If it is not suitable for the installation or has insufficient capacity, maintenance troubles are inevitable. The initial inspection of a new installation should be thorough and operation observed at load conditions before acceptance is made. A time schedule for routine inspection should be established to meet the service requirements. As motors and their starters are always associated, a combined schedule can include both.

No Lubrication on Bearings

Oil and grease should never be applied to the bearings of a contact or relay since either will cause dirt to accumulate and eventually result in a sticky, gummy accumulation and sluggish action. The bearings are designed so that no lubrication is required.

Bearing parts should permit contactors or relays to operate freely and without friction. If parts are out of alignment and excessive friction exists, the cause should be eliminated. Sluggish action will result in electrical troubles. Monthly inspections for severe service and semiannual inspections for average service will help prevent bearing and friction troubles.

No bearings are required when the moving parts of a contactor or relay are relatively light and the magnetic forces can be made strong enough to lift the movable parts vertically to close the contacts. This is an ideal design as far as bearings are concerned. However, the moving parts must be guided within the solenoid and nonmagnetic guides must be used to prevent magnetic sticking and sluggish action.

Mechanical Duty of Contacts

Although contacts are generally thought to be subjected primarily to electrical duty, mechanical duty is equally important. Endurance tests are made with no current through the contacts to observe how well they withstand the pounding, rolling and sliding or scrubbing action that occurs every time the contacts close. Contactor designs often provide a rolling action of the contacts so that the circuit is closed and opened on the contact tips instead of on the closed contact position.

When high currents that are difficult to interrupt are expected, powerful arc-rupturing structures are supplied to force the arc off the contacts and quickly extinguish it. These arc-rupturing structures are called arc boxes or blow-out structures. When in operating position, they surround the contacts and must always be in correct position to rupture the arcs effectively. They are easily removed for inspection or replacement of contacts and must be returned to correct position after inspection so that the arc will be properly broken and the contacts will not be unnecessarily worn and burned.

Contacts should be renewed when badly burned or pitted and when worn thin. They should be clean but need not be smooth. In fact, a clean contact with a roughened surface comparable to coarse sandpaper is satisfactory and provides a contact surface as good as or better than do perfectly smooth surfaces. If a contact surface is pitted or burned and not worn thin, it can be cleaned and used again.

The method of cleaning is important. Coarse and crude filing wastes material and generally deforms the original contact shape. The contact surfaces then have high spots and point contacts that are likely to overheat. Instead of filing, they should be cleaned with sandpaper or by a buffing wheel. A fine file is permissible if the contact shape is maintained. Emery paper should never be used as particles may adhere to the surface and cause needless wear.

Cleaning of Silver Contacts

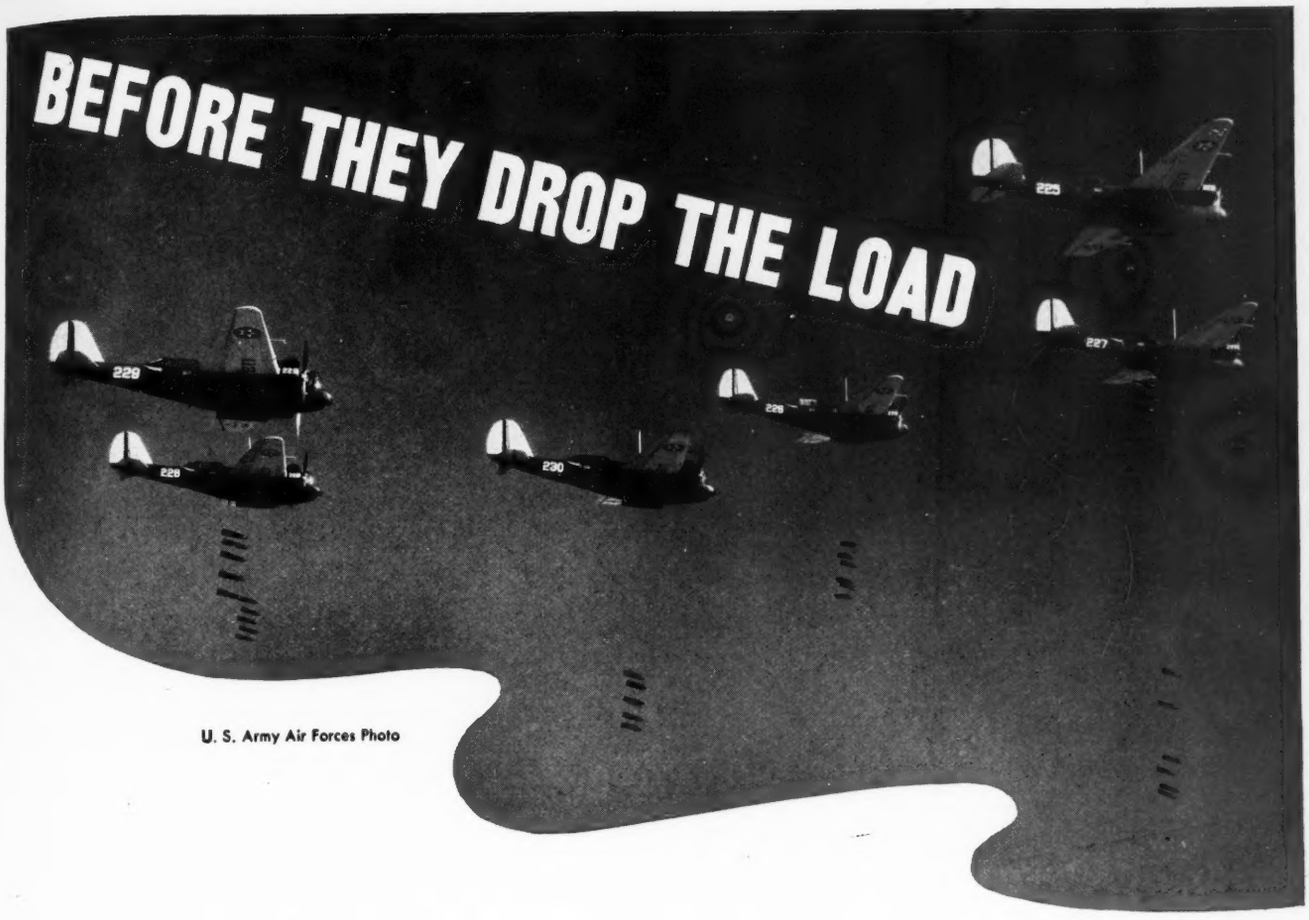
Silver contacts seldom require cleaning. They may look black and dirty because of the silver oxide, but as the oxide is a conductor, cleaning is seldom necessary.

When contacts are replaced, the surface against which they are bolted should be thoroughly cleaned. This is usually a current-carrying joint and a clean contact bolted to a dirty surface cannot give best results. Both surfaces should be clean. Any traces of copper oxide should be removed.

The screws or bolts that hold contacts in place must be tight. A loose contact surface offers high resistance and develops heat. This causes increased oxidation of the copper contacts. As copper oxide is not a good electrical conductor, this oxidation creates still more resistance and heat. This action is cumulative and eventually causes contacts to melt and brings about deterioration of the entire contact assembly.

When contacts open and close, the rolling and rubbing action combined with the slight burning of a normal arc keeps them bright and clean. If they operate infrequently, the cleaning action does not occur and a covering of copper oxide develops. The heating-oxidation cycle may start and eventually overheating may develop even though the current or load is normal or less. For such conditions, silver contacts will probably give better service than any other since silver oxide is a good

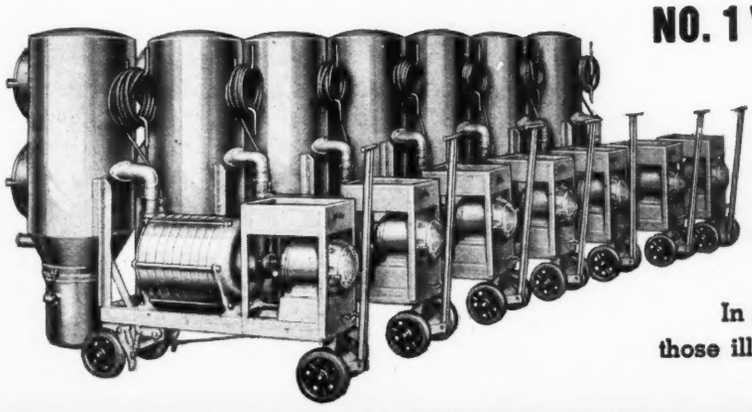
Assembled with the cooperation of J. O. Clevenger and L. E. Markle, industrial application engineer and motor control engineer, respectively, Westinghouse Electric and Manufacturing Company.



U. S. Army Air Forces Photo

HOFFMAN VACUUM SYSTEMS

HELP LOAD THE BOMBS!



NO. 1 WAR JOB for Hoffman Vacuum Systems is in Army and Navy shell and bomb loading plants. Special Hoffman Stationary Dust Removal Systems are daily rendering vital service on actual production operations—handling dusts from military explosives, eliminating dust hazards, and speeding up the rate of output. In addition, Hoffman vacuum cleaning units, like those illustrated, are also being used to promote good housekeeping in these important plants.

U. S. HOFFMAN MACHINERY CORPORATION
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COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

conductor and heating does not develop. Silver contacts may also provide some relief in cases where a small overload condition is troublesome. They must, however, be used with some caution because they will not correct overheating caused by loose connections. Since silver has a lower melting temperature than copper, silver contacts are more prone to become soft and "weld" or "freeze" together when subjected to high arcing temperatures.

The closed pressure of contacts is an important factor in their ability to carry current. A small contact with suitable contact pressure will carry more current than a larger one with little or no pressure. Renewal of thin contacts is required, as they lose their contact pressure with wear. It is important to keep the contact springs in good condition. They should be replaced if they have been damaged or have lost temper through exposure to high arcing temperatures.

Monthly Inspection Needed

A monthly inspection of contacts for pressure, available life, surface condition, temperature and tightness should suffice for normal conditions. For severe operating conditions a weekly inspection may be advisable.

Shunts are generally flexible bands of woven copper strands that carry current from the movable contacts to a stationary stud. If the shunt is unduly bent, its strands break and cause additional loading of the remaining strands.

Shunts with broken strands should be renewed to prevent overheating. The terminal connections of the shunt should be tight. Shunt ends are frequently silver plated or covered with special finishes to ensure a clean contact surface.

After coils are wound they are treated with insulating varnish to improve their di-electric strength and make them a solid mass. This makes the coil less susceptible to mechanical injury, eliminates air pockets within the winding and enables the coil to radiate heat readily.

Alternating current coils are designed to withstand 10 per cent overvoltage and operate the devices at 85 per cent of normal voltage. Direct current coils will stand 10 per cent overvoltage and operate devices at 80 per cent of normal voltage.

Overvoltage operates a contactor or relay with more mechanical force and tends to shorten the mechanical life, if allowed to prevail. It also shortens the life of a coil because it operates at a higher temperature. Low voltage will cause sluggish action. The contact tips may touch but may not be forced completely closed against the contact spring pressure. Under such conditions the contact tips will most certainly overheat and probably "weld" together. Contacts must always seal closed.

A.C. Coils

On A.C. service, the coil current is much higher while the contactor is closing than after it is closed. A.C. coils are not designed to stand the open-gap or closing current continuously. If any mechanical interference prevents complete closure of the magnetic air-gap of an A.C. device, its coil will soon be overheated.

Open-circuited coils are easily detected because they cannot operate the device. A voltmeter connected across the coil terminal would show zero voltage. A coil with some turns short-circuited might operate but it would soon overheat and burn out. Most designs permit quick and simple replacement of a defective coil.

When a magnetic contactor opens, the movable part strikes the stationary stop rather forcibly. There is a "dead," or center of percussion, point at which the effect of the blow is nullified. If the striking occurs at some other point, the device is subjected to mechanical vibrations and strains that reduce its mechanical life. This feature is vividly illustrated by the "sting" of a baseball bat if the ball strikes it somewhere near the end.

D.C. contactors always operate quietly when closed. A.C. contactors may be noisy.

The laminated magnetic structure, necessary on A.C. designs, must be held tightly together by screws, rivets or other means. If the laminations become loose, the assembly will be noisy.

Noise will also result if the movable and stationary pole pieces do not fit well together when the device is closed. Dirt or rust may prevent proper closure of these surfaces and cause objectionable noise. To prevent rust on these fitted surfaces during shipment some grease is applied. The excess grease should be removed when the device is placed in service to eliminate a "sticking" or sealing effect when the surfaces are first closed against each other.

Of most importance for reducing noise of an A.C. device is the shading coil, usually embedded in a part of the laminated magnetic structure. This coil is often a single turn of wire or strap and, if broken, the noise will be most objectionable. If the contactor is noisy, a broken shading coil should be sought.

Since many parts of contactors and relays are made of steel and subject to rust, these parts are always covered with a protective coating, such as zinc or cadmium plating. Copper and brass parts are often treated with a light finish to protect against oxidation and for sake of appearance. Steel cabinets are painted; small sizes often have baked finishes. Galvanized sheet is often used to give added assurance against corrosion.

In Explosive Atmospheres

For high-voltage installations, in explosive atmospheres and areas of corrosive nature, such as acid fumes, the entire equipment is often completely immersed in oil. The oil should be maintained at proper level and should be kept clean, especially when used for insulating purposes. A monthly inspection of oil-immersed equipment is adequate unless service is so severe that the oil deteriorates rapidly.

Explosion tested starters are intended for use in explosive atmospheres and do not require oil. These are built to specifications of the Underwriters' Laboratories. The enclosing cases are built to withstand high pressures that occur within the case if internal explosions should occur and to prevent flames escaping into the explosive atmosphere. If dismantled, the parts of an explosion tested starter must be carefully assembled to be sure that all bolts, nuts and joints are tight. Operation in the explosive area, unless starter is properly and completely assembled, is not permitted.

When oil or any liquid is used in dashpots, regular inspections should be made to be sure that the dashpots are free of friction and the proper oil level is maintained. The liquids used in dashpots are tested for certain characteristics, such as change in viscosity with temperature changes. A change in oil or liquid would, therefore, affect the operation of the relay. No substitution of oil or

DISINFECTAIRE

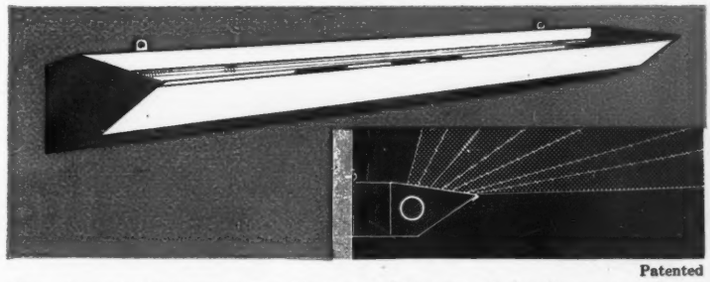
(REG. U. S. PATENT OFFICE)

Units for the Disinfection of Air

● Now you can minimize transference of infection in hospital wards, nurseries and other areas by use of DISINFECTAIRE—utilizing the General Electric Germicidal lamp.

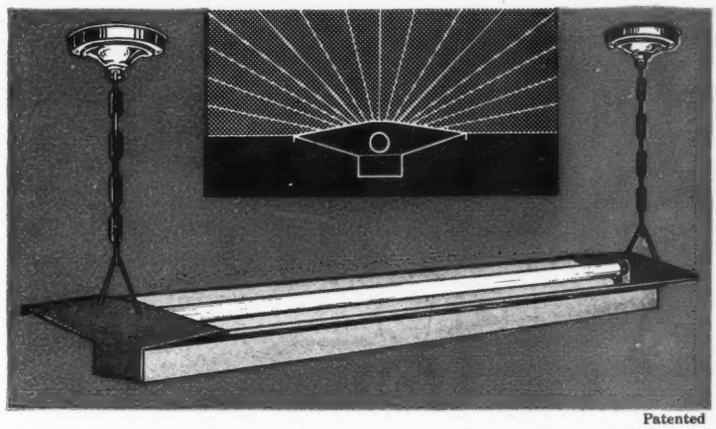
Air borne bacteria float suspended in prevailing air currents. One 30-watt DISINFECTAIRE unit will kill 90% of the disease producing germs in 700 cubic feet of air in one minute by means of ultraviolet germicidal radiation.

Units for complete irradiation of the upper areas of a nursery or hospital ward will create well defined vertical barriers from the upper irradiation area to the floor, of such lethal energy content as to kill all bacteria carried through them on ordinary air currents, *with complete freedom from erythema producing radiation.*



Patented

One 30-watt DISINFECTAIRE Unit will kill 90% of the disease producing germs in 700 cubic ft. of air in one minute. Controlled and safe.



Patented

Made for portable or permanent installation in wall and ceiling types in 15 and 30-watt sizes. Appearance and finish blend with any interior. Tamper proof.

CONTROLLED RADIATION
Efficient, Tamper-proof, Safe

Because of precision engineering, DISINFECTAIRE units give widespread distribution of the ultraviolet rays (2537A), which are at all times under control and confined *above* the normal line of vision. Reflector is permanently positioned, assuring safe, effective service.

The light from DISINFECTAIRE units is about the same color and brightness range as moonlight. The blue light emitted seems to be desirable for night lighting of sleeping rooms.

To secure the 2537A efficiency characteristic of germicidal lamps, the glass used in the G-E UVIARC must also transmit some 1850A radiation which produces OZONE. Under ordinary conditions of installation, the concentration produced is well under that of one part in one million accepted by the Council of Physical Therapy of the American Medical Association.

Accepted by
THE COUNCIL OF PHYSICAL THERAPY OF THE AMERICAN MEDICAL ASSOCIATION FOR HOSPITAL USE

May we send you the DISINFECTAIRE Catalog? It tells the story of DISINFECTAIRE and the background of this scientific development, including also important installation data and other valuable material. Sent on request.

Our Engineering Department will gladly cooperate with you.

THE ART METAL COMPANY

Manufacturers of Engineered Lighting and Ultraviolet Equipment

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liquid used in dashpots should be made.

Loose connections are a frequent cause of trouble. They result in overheated parts that eventually must be replaced. Once tight does not mean they will remain tight. Periodic inspection is necessary. Changes in temperature, vibration and carelessness are all common causes of poor connections. They should always be tight and clean.

Resistors frequently fail from excessive temperatures. Overheating may be caused by insufficient ventilation, excessive current overloading or more continuous service than was anticipated in the design. Loose connections often cause local heating with eventual burned connectors. Grid or cast types sometimes break in handling or with frequent and sudden overheating and cooling.

ENGINEERS' QUESTION BOX

Sweating Walls

Question 50: We are housed in a building constructed of concrete and brick with plaster walls. The walls of the operating and delivery rooms sweat terribly and then mildew. What methods of ventilation should I use to prevent this, or what is the best solution to this problem?—A.M.H., Ark.

ANSWER: The sweating of the walls is caused by the steam and vapor from the instrument and utensil sterilizer escaping into the rooms. The best way to avoid this trouble is to put a hood over the entire battery and connect this hood by means of a duct to the outside. In this duct a fan must be installed to draw the steam upward as fast as it is formed. This fan should have a speed controlled rheostat to govern the speed of the fan to suit all the conditions encountered.

If the sterilizers are not the cause of the trouble install in the ceiling of the rooms a large grille and connect this grille above the ceiling with a sheet metal duct, in which a fan is installed, discharging to the outside of the building.—E. W. RIESBECK, M.E., *consulting and construction engineer, Chicago.*

FISCHER WINS AWARD

The Engineers' Question Box Award for both April and May was made to Joseph C. Fischer, chief engineer, Milwaukee County Institutions and Departments, for his detailed discussion of testing fluorescent equipment, which was published in two sections.

Conducted by Alta M. La Belle

Safety *Is Your Business—I*

DON C. HAWKINS

Executive Field Representative
St. Paul Mercury Indemnity Company

IN GENERAL, accidents and claims arise from two sources: physical conditions, such as slippery floors, broken furniture, explosions and fires, and what is generally termed malpractice, including improper treatment, wrong dosages and burns.

Oddly enough, the line of distinction is surprisingly fine and many a case has been handled as malpractice that resulted entirely from physical failure and would not normally be considered as malpractice by the hospital. We shall take up some of the commoner causes of trouble that are based on physical conditions or routines.

When and How to Wax

Floors are always a problem. Everywhere we go we meet the questions, "What flooring is best?" "How do we treat it?" "What wax is best?" A wide difference of opinion precludes a definite answer to these, but we have found out for sure that too much wax on any floor is bad.

Good wax properly applied is not seriously dangerous, but it should be applied lightly and worked in thoroughly. At one hospital I visited, a nurse fell in a hall just as I entered with the director. The floors were so slippery we could walk only with difficulty. His explanation was that he had just purchased a new polisher and the porter liked to run it so well that he waxed the floors every day. My advice would be to hire a porter who doesn't like polishers that well and also to thin the wax to the maximum.

Gleaming waxed floors are no longer in vogue and a lot of bad falls can be traced directly to them. Whatever the flooring is made of it should not be slippery.

Too much water on linoleum usually soaks through the joints and rots the burlap base or loosens the cement, but used lightly it can do a good job of cleaning.

Small, loose throw rugs are never safe in any public building. They slide on a slippery floor, curl up or wad up and if they are considered absolutely necessary they should be tacked down or good nonslip pads should be put under them.

A common source of falls is poor stair treads. If you are lucky and have a modern building there is probably abrasive in the concrete that makes a safe stairway, but brass nosings or carpet runners need constant supervision if bad falls are to be avoided. Most state or city laws require hand rails on all stairs and that condition has improved, but architects have shown a surprising lack of interest in providing rails for outside entrance steps.

Outside steps are usually of stone or some hard substance that gets very slippery with rain or snow and the hospital's obligation to visitors and lame and weak patients certainly requires the best possible rail protection. Far too many entrances are left bare and dangerous merely to satisfy some mistaken sense of beauty.

Dark stairways, especially those leading down behind closed doors, are traps and should be well lighted and warning signs should be placed on the doors. In one hospital there were two bad falls on such a stair in one month after the light had been turned off to save electricity.

Another source of falls is foot stools. They are commonly used in all patients' rooms, x-ray and examination rooms and are made small to save space. The size is not important, but they must be so constructed that the top edges do not extend out over the feet or the patient's weight easily tips the stool. One such stool caused a fractured skull. You can well afford to test them carefully, discard some and make safe the ones you keep. The edges can be trimmed down or the feet extended out on many types now in use.

Broken or patched ladders, chairs or boxes in stockrooms should be destroyed or repaired. Never let them lie around on the theory that they will not be used. Dark steps, small ramps and low head room can be marked with black and white paint in stripes to warn persons not familiar with them.

There are many interesting phases of the subject of explosions. For example, we should bring up the careless use of ether in all parts of the hospital for cleaning and other utility purposes. A safety man would be horrified if he found an industrial plant in which such conditions existed. In nearly every hospital we find bottles and cans of all sorts full of ether and placed with absolute disregard to flames or heat. In fact, the surest place to find ether in a laboratory is close to a bunsen burner.

In a large Chicago hospital we found a gallon glass bottle full of ether on a high shelf less than 6 feet from a gas oven. Had this bottle tipped over (it had a loose cork) or fallen on the hard floor, it would have been impossible to shut off the oven in time or to have avoided a serious fire or explosion.

Ether is one of the most dangerous of the flammable liquids yet it is often discovered scattered freely around on trays, in kitchens and in boiler rooms and closets. There have been a number of explosions already and if the practice isn't stopped, we can expect another catastrophe similar to the Cleveland film disaster.

Use Noninflammable Solvents

Carbon tetrachloride has been entirely substituted in many hospitals for all utility purposes and ether is prohibited except for anesthesia. A number of commercial solvents that are noninflammable are said to do all that ether can do and they are safe.

If you do keep ether for special purposes, keep it in a metal can that won't break and with a screw top that can't fall out or permit leaks. A refrigerator is not a bad place in which to store ether. Don't substi-

From a paper presented to the housekeeping section, Tri-State Hospital Assembly, May 1944.

tute benzene or acetone for ether as either one is flammable.

A few pathologists have objected to carbon tetrachloride for fear of toxic poisoning. We recognize this possibility as some deaths have occurred when it was used in large quantities and the fumes were inhaled, but the amount used in hospitals is small and the conditions are such that the danger is remote. The government does not require a safety label on less than pint cans.

(Mr. Hawkins' article will be concluded in the July issue.)

Central Linen Room

Recently, a reader inquired as to the advantages or disadvantages of a central linen room in a 200 bed hospital. The question was referred to Mildred Burt, executive housekeeper at Mountainside Hospital, Montclair, N. J., whose reply is presented for the benefit of other housekeepers who are pondering on the advisability of installing such a system in their own institutions:

The advantages of a central linen room in a 200 bed hospital are: (1) smaller inventory requirements; (2) less time required by too busy nurses on the floors in checking both soiled linen to go to laundry and clean linen coming from the laundry; (3) better control of flow of linen from the laundry when it all goes to one point, the central linen room, than when there are many different floors receiving it.

When linen is returned directly to the hospital floors, it is necessary to provide sufficient linen to cover the highest possible census on each floor.

Even then, with an extremely high census or when there are cases requiring an excessive amount of linen, there would be times when some of the floors would run short of linen. On other floors where the census might have taken a sudden drop, at that very moment, there might be a considerable amount of extra linen lying unused.

With a central linen system, this extra linen would be sent where it was most needed and the floor with lower census would receive only the linen required to cover its needs at that particular time.

Consequently, it is possible to operate with a lower inventory under a centralized linen control system than is possible when each floor must at all times have in stock sufficient linen to cover its greatest needs.

With a central system, less time is required by employes on a floor in handling linen than in a system where linen is sent directly to the laundry from the floors and received directly back on the floors from the laundry.

Nurses are trained to care for the sick and in these times are hard to find, and they should not have to struggle with checking soiled linen in and out and rechecking it when it returns clean.

There is no flexibility in a system in which the linen is marked for the floor to which it belongs and then washed, sorted and returned to the floor from which it came by the laundry. The laundry has no way of knowing which floor needs its linen first and linen may not rotate through the laundry according to the needs of the departments. Also, a time and labor element is involved in sorting each piece according to its marking.

While in the central linen room system, it is, of course, necessary to furnish a worker to take charge of the linen room, this system removes a considerable amount of work from those located on the various floors and in the laundry. The head of the linen room will become a specialist in the handling of linen and, if she is capable, will be able to keep the various floors supplied with the necessary linen, provided the hospital receives the complete cooperation of those on the floors in their requisitioning of linen. Thus, in the long run, the expense is no greater for the hospital.

COW Belongs in EVERY Hospital and Institution"*

* *From a recent statement by the Medical Director of a private sanitarium using a Mechanical Cow.*

The Mechanical Cow makes it possible for every hospital, sanitarium or other institution to have complete control over its own milk supply . . . in quality, purity, uniformity, dependability and cost.

This revolutionary machine, for the first time, provides a simple, effective method of producing pure, delicious milk, cream and ice cream mix, of any desired butterfat content, in any quantity, at any time. These products are not synthetics or substitutes, but contain all the proteins, fats and minerals of the natural products.

The Mechanical Cow has proved itself in hundreds of highly successful installations on U. S. Naval vessels and at U. S. Navy, Marine and Army bases throughout the world.

Here are some of the advantages which it offers:

Lower Cost . . . In most sections of the country, real milk and cream can be produced by the Mechanical Cow at a cost 30% to 50% less than regular dairy prices.

Controlled Quality . . . Butterfat content can be governed exactly in Mechanical Cow products. Their nutritional value is the same as that of fresh products.

Excellent Flavor and Body . . . In flavor and body, these products are the equals of the finest dairy milk and cream. They are completely homogenized.

Greater Purity . . . Mechanical Cow's milk and cream have a much lower bacteria count than the purest dairy products. (Bacteria count of 70 to 80, as compared with 50,000 permitted by many cities.)

Absolute Uniformity . . . There is no variation in quality, flavor, body and purity.

Dietary Control . . . It is possible and practical to add such food elements or vitamins, particularly the new fat-soluble Vitamin C, as indicated by special diet requirements. For the first time, you can make a milk to order . . . low butterfat for infants, high butterfat for older persons and convalescents.

Dependable Supply . . . You control your own supply and are not dependent upon an outside source.

Illustrated at the left are two models of the Mechanical Cow especially adaptable for hospitals and sanitariums. Eight other models provide capacities up to 100 gallons per hour. Complete information will be sent upon request. Be sure to specify number of beds (or patients). Use the convenient coupon below or write to . . .

UNITED DAIRY EQUIPMENT COMPANY
WEST CHESTER, PA.

Please send me complete information on the Mechanical Cow.

With ice cream freezer ☐ Without ice cream freezer ☐ *(Please Check)*

We have_____beds. (fill in number)

NAME OF INDIVIDUAL_____

TITLE_____

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West Chester, Pa.

NEWS IN REVIEW

Attendance Record Broken as 5000 Gather for Tri-State Hospital Assembly

With an attendance of more than 5000, the fifteenth annual Tri-State Hospital Assembly in Chicago on May 10 to 12 exceeded all previous records. Fifty-nine sections and organizations, in addition to the sponsoring Illinois, Indiana, Wisconsin and Michigan hospital associations, took part in the program. Several hundred speakers participated.

"The voluntary hospital may choose to be strictly a private enterprise with little claim to public service, self-centered, concerned only with curative medicine and only with patients in certain economic strata. Or it may choose to be a part of an expanding program of community effort for public health and welfare, responsive to public needs and a partner with other private and governmental agencies in these fields," declared Lt. Col. Basil C. MacLean, M.C., U. S. Army.

The former path will lead to a system of private nursing homes and another separate system of governmental hospitals with broad responsibilities, he said. The other path will bring the voluntary hospital to a position of pre-eminence among American institutions and to a measure of usefulness much greater than it has yet attained, he prophesied. Doctor MacLean's paper will appear in a future issue of The Modern Hospital.

Stress Importance of Learning

The importance of life-long learning to hospital administrators was stressed by Ralph McCallister, director of the Adult Education Council of Chicago. Such a need is obvious from the professional point of view in a field that changes as rapidly as does any field connected with medicine, he told a luncheon meeting sponsored by the A.C.H.A. But adult learning is also necessary to good life as a citizen.

The training of workers and professional people takes only about half as long as we had previously thought, declared Prof. William R. Spriegel, chairman, department of management of Northwestern University. He cited the case of tool and die makers whose training has always taken four years but now has been successfully condensed to two. Although it may do violence to many of our own pet phobias, he declared, nurses also can be properly educated in much less time than heretofore.

Hospitals have for far too long been low bidders on the labor market in the opinion of Robert E. Neff, administrator, University of Iowa Hospitals. We should educate the public to the higher costs of good hospital service.

Hospital salaries will never again sink to the low levels that were prevalent during the past decade, in the opinion of James C. Downs Jr., manager, Jackson Park Hospital, Chicago. Study of previous business cycles and inflation has led him to the conclusion that wages and salaries go up and down but after they have gone up substantially they never come down as far as the starting point.

Adequate medical and hospital care is now denied to some segments of our population in the opinion of Rev. John W. Barrett, diocesan director of Catholic hospitals, Chicago. While opposing the sweeping provisions of the Wagner-Murray-Dingell Bill, the Rev. Father declared that he is not wedded to the status quo.

Urge Support for Blue Cross

Strong support for the comprehensive uniform national contract for Blue Cross plans was voiced by Dr. Herman Smith, administrator, Michael Reese Hospital, Chicago, who stated that it is the hospital's duty to advance the banner of health and to make hospital service available to all people as easily as possible. If hospital administrators will insist that all patients receive complete and adequate service, we shall have a uniform contract almost overnight, he said.

About 700 people turned out for the banquet to hear J. Howard McGrath, governor of Rhode Island, describe his plan of compulsory hospital insurance at the state level. So many introductions and speeches preceded the governor's talk, however, that the audience was exhausted before he spoke. The banquet lasted more than five hours.

"Trustee representation must be broadened to include the ablest leaders in law, banking, commerce, industry, religion and, yes, labor and politics. Our voluntary hospitals are worthy of and must have the best brains in America," said Everett W. Jones of The Modern Hospital in discussing the personnel problem. He urged adequate salaries and wages, pensions, good equipment and working conditions, adequate restrooms and recreational facilities and skilled supervision.

A national hospital standards council should be formed to set standards for hospital design and equipment, in the opinion of Dr. Vane M. Hoge, U.S.P.H.S.

It might be made up of the technical experts in the hospital facilities section of the U.S.P.H.S. and representatives of the three national associations.

Illinois Officers

President, Frank W. Hoover, Decatur and Macon County Hospital, Decatur.
First Vice President, Myrtle McAhren, Blessing Hospital, Quincy.
Second Vice President, Rev. John W. Barrett, director of hospitals, Archdiocese of Chicago.
Trustees, Dee Elsome, C. Norman Andrews, E. W. Wegge, Leo M. Lyons, F. Jane Graves, Rev. Joseph A. George and Charles A. Lindquist.

Indiana Officers

President, Sister Mary Reginald, Mount Mercy Sanitarium, Dyer.
President-Elect, Dr. Charles W. Myers, City Hospital, Indianapolis.
Vice President, E. C. Moeller, Lutheran Hospital, Fort Wayne, Ind.
Treasurer, Sister Teresa, St. Mary's Hospital, Evansville.
Executive Secretary, Albert G. Hahn, Protestant Deaconess Hospital, Evansville.
Trustees, Frank G. Sheffler, Sister M. Calista and Maude M. Woodard.

Michigan Officers

President, Dr. Leverett S. Woodworth, assistant director, Harper Hospital, Detroit.
President-Elect, Rev. J. L. Ernst, superintendent, Deaconess Hospital, Detroit.
Vice Presidents, Cora E. Barber, assistant superintendent, Butterworth General Hospital, Grand Rapids, and Alice E. Snyder, superintendent, St. Luke's Hospital, Marquette.
Trustees, Sister Marie Bernard Masterson and Graham L. Davis.
Secretary-Treasurer, Robert G. Greve, assistant director, University Hospital, Ann Arbor.

Federal Pay Set at Twice Civilian for Senior Cadets

WASHINGTON, D. C.—The argument between civilian hospitals and certain government agencies was terminated on May 4 when President Roosevelt signed Executive Order 9439 setting $60 per month plus maintenance as the rate of pay for senior cadets in federal hospitals and agencies.

Certain government officials had wished to support the position of the civilian hospitals in favor of a $30 salary. No effective support for this position was forthcoming, however.

From information collected at various hospital meetings, it appears that most nonfederal hospitals expect to pay $30 but a few are going above this level.

The officers and trustees of the Wisconsin Hospital Association on April 14 unanimously adopted a motion recommending that hospitals in that state pay $30.

New York Trustees Hear About Social Service

The importance of the medical social worker in the hospital pattern in war time was brought to the attention of hospital trustees and committees in a forum held May 4 in the headquarters of the United Hospital Fund in New York under the auspices of the Medical Social Service Council.

In 1937 there were only two departments to train students in this field, according to Roy E. Larsen, president, United Hospital Fund, New York, whereas today there are 15 with five more ready to carry on.

Dr. Claude Munger, director of St. Luke's Hospital, explained that since the passing of the family doctor the medical social worker must take over his function as personal adviser to the patient. Other speakers on this occasion were Dr. Philip Wilson, president, National Council of Rehabilitation and surgical director of the Hospital for Special Surgery, and Frederic G. Elton, district supervisor of the state bureau of vocational rehabilitation.

Induct Cadet Nurses in National Ceremony

WASHINGTON, D. C.—A national induction ceremony on May 13, held simultaneously in the 48 states for 96,000 cadet nurses, gave recognition to their important service from leaders of the federal government.

Among those participating in the Washington program, which had a nationwide broadcast over N.B.C., were Surgeon General Thomas Parran, U.S.P.H.S., Paul V. McNutt, Federal Security Administrator, Mrs. Frances Bolton, Mrs. Franklin D. Roosevelt, Lucile Petry and Helen Hayes. The program was held in Constitution Hall, when 750 cadet nurses took solemn pledge of their obligations to their country and their profession. Bing Crosby sang from Hollywood. Capt. Burgess Meredith, U.S.A.A.F., was master of ceremonies.

In Chicago, a similar ceremony was held with the national broadcast as the heart of the program. One hundred cadet nurses participated and 200 prospective nurses formed part of the large studio audience. Stanley R. Clague, president of Chicago Rotary Club, presided. Governor Dwight Green made the other principal talk. Representatives of the Army and Navy nursing services were present to answer questions.

In Atlanta, the local program was held in the city auditorium and a special section was reserved for student pledges. In North Dakota the governor administered the pledge. In Boston cadet nurses marched from the State House to Boston Common for the ceremony. In Arkansas the governor administered the pledge over a statewide hookup following the national ceremony. Large group ceremonies were held in many other cities.

Food and Drugs Commissioner Retires

WASHINGTON, D. C.—The retirement of Walter G. Campbell, U. S. commissioner of food and drugs, was announced April 30. Commissioner Campbell entered the federal service as chief food and drug inspector in 1907. When the Food and Drug Act of 1906 became effective, he organized under the general direction of Dr. Harvey W. Wiley the small staff of food and drug inspectors on a nationwide basis and formulated plans for inspection operation. Mr. Campbell was instrumental in obtaining the passage of the federal Food, Drug, and Cosmetic Act of 1938, one of the most effective laws ever enacted in the interest of consumer protection. Dr. Paul B. Dunbar has been appointed to the commissionership and Charles W. Crawford has been made second ranking officer.

New Jersey Group Considers Pensions, Compensation Rates and Volunteers

A committee to study pension plans for hospital employes was authorized by the New Jersey Hospital Association at its meeting in Atlantic City May 10 to 13. In point of program and general interest this meeting, which marked the twentieth anniversary, was generally conceded to be one of the best.

A resolution requested the hospital service plan of New Jersey to take into account the differences in service resulting from differences in equipment and physical properties by paying rates to hospitals comparable to the revenue received from uninsured patients receiving similar services.

For compensation cases New Jersey hospitals are receiving $5.50 per day for the first week and $5.25 per day after that period. It was agreed that the member institutions should lose nothing on compensation insurance and accordingly efforts are being taken to increase this to $6 as a minimum.

The convention recommended that $30 be paid to senior cadet nurses despite government action to raise this amount to $60.

Dr. J. A. Curran, president and dean of the Long Island College of Medicine, expressed the opinion that hospitals will revert to the one or two year internship plan just as soon as the medical schools abandon the accelerated curriculum. Since Army authorities foresee a 50 per cent reduction in the need for medical officers in 1948, Doctor Curran believes it probable that the medical colleges will consider the admissions of first year classes only once a year starting in October 1945. However, the three-year accelerated course will be continued until the end of the war which will mean a new problem for hospitals.

Graduation of classes at irregular intervals during the year will mean a series of uneven overlappings of intern services until we are finally back on the pre-war graduation of classes in June and the beginning of internships on July 1. It may take three to four years to reach this goal and the resultant interference with educational programs is bound to be serious.

"It is my hope," Doctor Curran stated, "that all medical schools in the United States at their annual meeting in October will agree not to release information regarding internship candidates until after the conclusion of the junior year. If the A.H.A. and the A.M.A. will lend their support to this project, a real basis for wiser selection will be laid."

Volunteers came in for their due share of recognition with George H. Buck, superintendent, Mercer Hospital, Trenton, describing his experiences with male volunteers and Mary T. Mooney, secretary, Catholic Hospital Council of New Jersey, presenting an overall picture of volunteer activities in hospitals today.

A report on discussions with the New Jersey pension survey commission on various types of pension plans that might be applicable to hospitals was submitted by Rev. John Martin, superintendent, Hospital of St. Barnabas and for Women and Children, Newark. It was agreed that the association should have a committee to exhaust the various possibilities of pension plans.

With Atlantic City the center of rehabilitation activities of the armed forces, the subject of war casualties occupied an important place on the program. The handling of Navy war casualties was described by Capt. Lewis K. Ferguson, U. S. Naval Hospital, St. Albans, L. I. Following his talk Col. Patrick J. Cooney, England General Hospital, Atlantic City, spoke on Army war casualties and invited members of the association to visit that institution.

Officers for the coming year are J. Ellis Behrman, superintendent, Beth Israel

Hospital, Newark, president, succeeding Dr. J. Berkeley Gordon of the New Jersey State Hospital, Marlboro; Charles Lee, East Orange General Hospital, East Orange, president-elect, and Frank B. Gail, superintendent, West Jersey Homeopathic Hospital, Camden, vice president. Dr. George O'Hanlon, Medical Center, Jersey City, continues as executive secretary and Thomas J. Golden, Medical Center, Jersey City, as treasurer.

An invitation was extended to the New York Hospital Association to meet with the New Jersey group next year in Atlantic City.

Approve Construction of $1,204,000 Hospital in Utah

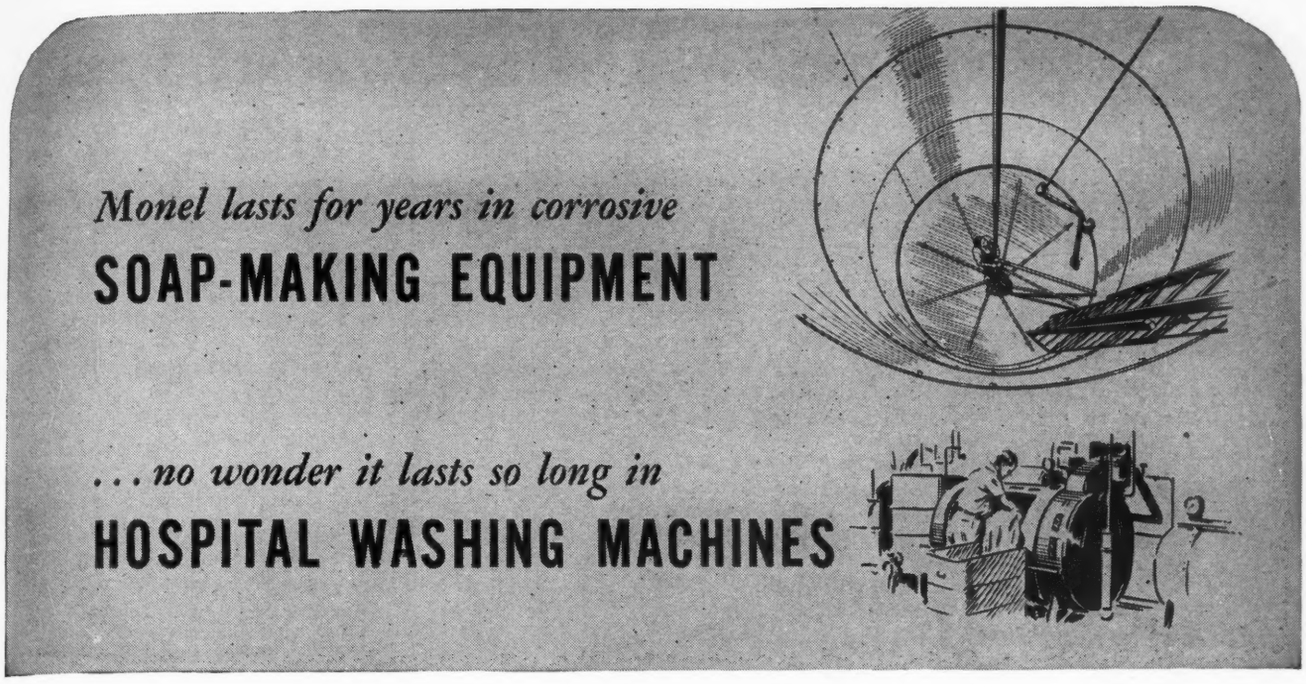
WASHINGTON, D. C.—Included in presidential approval of war public works is a $1,204,000 hospital at Ogden, Utah. Other hospital construction projects approved by W.P.B. from April 10 to May 13 include the following costing over $100,000 each:

Anniston Hospital, Anniston, Ala., $150,000; St. Joseph's Hospital, Mitchell, S.D., $130,000; St. Joseph's Hospital, Chicago, $186,500; construction of hospital to replace one condemned, Ontonagon, Mich., $135,000; St. Joseph's Hospital, Alton, Ill.; $142,660; St. Mary's Hospital, Pueblo, Colo., $128,125; Southern Baptist Hospital, New Orleans; $105,000;

Veterans Administration, neuropsychiatric hospitals at various locations, $29,203,165; Minneapolis General Hospital, Minneapolis, $290,000; Miller Hospital, St. Paul, $220,000; North Carolina Baptist Hospital, Winston-Salem, $129,000; St. Luke's Hospital, Duluth, Minn., $125,000; St. Catherine's Hospital, Omaha, Neb., $145,000; University of Iowa General Hospital, Iowa City, $205,000; Veterans Administration Hospital, Wadsworth, Kan., $952,177; Mercy Hospital, Cedar Rapids, Iowa, $117,000; St. Mary's Mercy Hospital, Gary, Ind., $107,830; St. Elizabeth's Hospital, Youngstown, Ohio, $269,648; Watts Hospital, Durham, N. C., $196,900.

Army Requires 50,000 Nurses

WASHINGTON, D. C.—The authorized strength of the Army Nurse Corps has been established at 50,000, according to a recent announcement of the War Department. More hospital trains, more station and general hospitals, the demand for nurses on ship board, all account for the increase. The authorized strength given is a ceiling and actual appointment of nurses will depend on Army needs in relation to casualties and by the rate civilian nurses are made available by the Procurement and Assignment Service.



Modern soap plants ... as well as the hospital laundries they serve ... need *tough* equipment.

Fats and oils, acids, caustics and salt used in soap making are highly corrosive ... special care is required to prevent discoloration and odor which might result from metallic contamination.

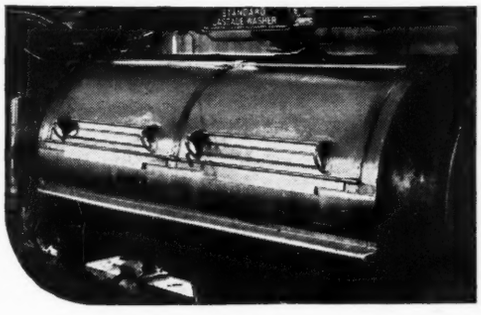
Monel is widely used in soap making equipment ... in boiling kettles, heating coils, fat storage tanks, bar cutters and soap flake dryers ... in all places where rust and corrosion threaten purity.

In soap plants, long-lasting Monel helps to provide you with clean, pure soap. In hospital laundries, this same rustproof, corrosion-free metal protects linen from stains and damage.

As shown here, Monel lasts for years ... even under the severe corrosive conditions encountered in soap plants. Small wonder, then, that many Monel hospital washers ... in continuous use for more than a quarter of a century ... *are today as serviceable as when they were new.*

After today's demands have been met, Monel will again be available for those who want economy and long life in their laundry equipment.

Section of Monel pipe from a heating coil used in the manufacture of soap. After more than 19 years of service, Monel shows complete resistance to the caustic soda, salt, acids and steam encountered.



This Monel hospital washer is still on the job after 25 years of service ... still washing linens safely ... thoroughly ... economically.

The International Nickel Company, Inc., 67 Wall St., New York 5, N. Y.

MONEL saves $ $ $ $ $ in the laundry — labor, soap, power, water, supplies

Failed Tuberculous in Last War, Dublin Says

"The pattern of service to tuberculous veterans of World War I has been so poorly planned that it actually leads to the gradual but certain breakdown of most of these patients; with few exceptions, these veterans do not get well. This is in sharp contrast with the much more favorable record over the same twenty-five years for tuberculous patients entering state, county and private sanatoriums."

This striking challenge to the Veterans Administration was a high point of the 40th annual meeting of the National Tuberculosis Association, held in Chicago on May 9 to 12. The speaker was Louis I. Dublin, third vice president and statistician of the Metropolitan Life Insurance Company and former president of the American Public Health Association. His statements were supported by other students of the tuberculosis problems but Colonel Roy A. Wolford, assistant medical director of the Veterans Administration, predicted improved end results for veterans of World War II.

The bad showing made by veterans' hospitals in this respect arises primarily from the fact that the medical staff has not been given the necessary control over their tuberculous patients. The veterans come and go at will, with the result that their physical condition deteriorates and sooner or later they die of their diseases. In the meantime, they often infect members of their families or other persons in their home communities, Doctor Dublin charged.

Many veterans, he said, actually obtain larger financial benefits by going home than by staying in the hospital until they are better. Congress should change this provision and should provide that veterans either remain in federal hospitals until their disease is arrested or be under control of local public health laws.

Of nearly 700,000 people given chest x-rays by the U.S.P.H.S. in cooperation with state and local health departments, 1.3 per cent had tuberculosis, according to Dr. Herman E. Hilleboe. One third of the cases were active. The tuberculosis death rate among Negroes is about 3½ times that among white persons, he said.

Routine x-raying of 15,000 patients examined in 1943 in the out-patient departments of the University of Chicago Clinics resulted in finding 4.1 per cent with active tuberculosis previously unsuspected, according to Dr. Robert G. Bloch and Dr. William B. Tucker. Also 8 per cent of the patients had abnormal heart conditions, which were revealed by the x-rays. The simple procedure of x-raying showed up previously undiscovered pathologic conditions in 21.5 per cent of the group.

A complete x-ray laboratory on wheels, especially adapted for mass chest examinations, was exhibited at the convention. It belongs to the Iola Monroe County Sanatorium in Rochester, New York, and will be used to examine the chests of industrial workers in the Rochester area.

The 2 ton truck has a new type of x-ray apparatus known as a photoroentgen unit. It produces an x-ray image of the chest on a 4 by 5 inch x-ray film. Two examinations can be made a minute. Three dressing rooms and a lead-lined dark room can function whenever the truck stops. It is heated for winter use.

Army to Return Breakers Hotel

WASHINGTON, D. C.—The Army will return the Breakers Hotel at Palm Beach, Fla., to its owners on Dec. 11, 1944, the War Department has announced. The hotel has been operated under temporary lease as an Army hospital since March 1943. Beds have been or are being provided to meet satisfactorily the Army's general hospital requirements without this facility. Patients now occupying the Breakers will be distributed as nearly as possible to Army hospitals in the vicinity of their homes.

Levi Hospital Offers Aid in Physical Therapy Study

Leo N. Levi Memorial Hospital, Hot Springs National Park, Ark., announced on May 6 that it had offered to "turn over to the Medical College of Virginia, Richmond, Va., newly designated center for research and teaching in hydrology and spa therapy, the hospital's entire facilities and scientific records as its contribution to further enlightenment in the field of reconditioning of wounded service men."

This offer was an outgrowth of the donation of $1,100,000 on April 27 by Bernard M. Baruch, financier and presidential adviser, for the development of physical medicine. Mr. Baruch's magnificent gift was accompanied by a report of a committee on physical medicine headed by Dr. Ray Lyman Wilbur of Stanford University. The report recommended a nation-wide increase of this healing, particularly for returning soldiers.

The committee defined physical medicine as the use of light, heat, water, cold, electricity, massage, manipulation, exercise, spas, climatology and hydrology, the last specializing in baths, sprays and other forms of hydrotherapy.

The Leo N. Levi Memorial Hospital, of which Regina Kaplan is administrator, is unique in being the only free hospital in the world, national and nonsectarian, which specializes in the treatment and care of arthritis, rheumatism and kindred diseases. It was founded and is maintained by B'nai B'rith.

Of Mr. Baruch's gift, $400,000 goes to Columbia University College of Physicians and Surgeons for a key center of research and teaching in physical medicine; $250,000 to New York University College of Medicine for teaching and research in preventive and manipulative structural mechanics of physical medicine; $250,000 to the Medical College of Virginia for teaching and research in hydrology, climatology and spa therapy; $100,000 to selected medical schools to develop an immediate program for the physical rehabilitation of war casualties and industrial injuries, and $100,000 for fellowships or residencies in this field.

Mr. Baruch's father, Dr. Simon Baruch, was a graduate of the Medical College of Virginia and a distinguished surgeon in the Confederate Army.

Navy Patients Transported Across Continent by Air

WASHINGTON, D. C.—The Navy inaugurated a new service April 23 when an airplane ambulance flew a group of patients from Washington, D. C., to the U. S. Naval Hospital at Corona, Calif. Overseas airplane evacuation of the disabled from forward to rear areas has been conducted on a systematic basis since the first Solomons operations in 1942. In the United States, air ambulance transport for shorter distances has been practiced for many months but this is the first time in American military medicine that a large group of patients has been enplaned for a transcontinental destination.

The sailors and marines, all suffering from rheumatic fever, were taken to the naval hospital at Corona where there is specialized treatment for this disease. Rheumatic fever cases can be transported by air at ordinary altitudes in perfect safety.

Called Army Nurse's Aides

WASHINGTON, D. C.—Maj. Gen. Norman T. Kirk, surgeon general of the Army, has authorized the full-time employment in military hospitals of certified graduates of volunteer nurse's aides classes sponsored by the American Red Cross, it was learned in an interview May 8 with Mrs. Walter Lippmann, head of the nurse's aide program. With uniforms and insignia of their own, they will be known as "Army Nurse's Aides."

Affiliations for Senior Cadets Grow in Number

WASHINGTON, D. C.—Plans for the use of senior cadets are being made by health departments, health agencies and hospitals with no schools of nursing, according to an announcement May 5 of the Division of Nurse Education, U.S.P.H.S.

This distribution of senior cadets for practice under planned supervision works an advantage to the receiving institution by providing it with increased nursing personnel and to the home hospital by providing additional space for incoming classes.

Toledo State Hospital, Toledo, Ohio, has arranged for the supervised training of two senior cadets from the Warren City Hospital School of Nursing, Warren, Ohio. Norwich State Hospital, Norwich, Conn., offers training in psychiatric technics. Some of the cadet nurses receive training in rural community hospitals, others in sanatoriums in which patients with tuberculosis receive convalescent care.

The Southwestern Michigan Hospital Council, composed of representatives of 19 small hospitals, is also cooperating. Working with the W. K. Kellogg Foundation, five of these will be available to receive cadet nurses by June 1.

The Georgia Department of Public Health conducts a program in which senior cadets receive supervised practice in public health nursing on the staffs of local health departments. The departments have been approved by the state board of nurse examiners.

Four students from Johns Hopkins Hospital will spend their senior cadet period with the Frontier Nursing Service in Hyden, Ky. The Frontier Nursing Service will provide for the maintenance of cadets and their horses, riding uniforms and allowances.

A.C.H.A. Seminar for Fellows Reported "Great Success"

Of the 27 fellows of the A.C.H.A. who registered for the first educational seminar for fellows held at the University of Minnesota on April 25 to 28, all were well satisfied, according to reports submitted at the conclusion of the conference. One fellow said it was "the finest educational program I have enjoyed since I attended college."

Actually, 32 men attended the sessions, in addition to the faculty. Twenty-three of them attended every session. The meetings were from 8:30 to 11:45 a.m. and from 1:30 to 5 or 6 p.m. No evening sessions were scheduled.

Many of the leading hospital administrators of the country attended the seminar. The college hopes to hold similar seminars in other parts of the country.

Scholarships for Graduate Study

WASHINGTON, D. C.—A memorandum to graduate nurses dated May 8 from Lucile Petry, director, Division of Nurse Education, U.S.P.H.S., calls their attention to scholarships for postgraduate study provided under the Bolton Act. These scholarships are designed to increase the number of graduate nurses prepared for critical nursing positions which require special preparation. They offer carefully selected graduate nurses splendid opportunities to prepare for key positions in fields where definite shortages now exist.

Nine Army Nurses Reach China

Nine officers of the Army Nurse Corps arrived in China several weeks ago to become the first Army nurses to be assigned to hospital units in China, according to an announcement of the War Department May 12. They will work side by side with the Chinese nurses who have done excellent work in caring for sick and wounded American troops in China. Flight nurses have been evacuating wounded from China for some time during the present war.

A.H.A. to Act on Rural Hospital Problem, Midwest Group Told

The A.H.A. committee on postwar hospital planning is proposing to take the offensive and to do something about the rural hospital problem, stated Graham Davis before the seventeenth convention of the Midwest Hospital Association held in Kansas City on April 20 and 21. The quality hospitals, as indicated by A.C.S. approval, are concentrated in the urban areas, Mr. Davis stated. We anticipate that the commission will recommend the integration of hospitals and that rural hospitals will become real health centers, he stated.

The Midwest meeting was well attended, not having suffered from omission last year.

The legislative committee proposed and the convention endorsed the idea of organized coordinated planning committees in each state to bring about an extension and better integration of medical care and hospital service to all the people, especially in rural areas and smaller cities.

They also urged a committee to develop machinery for effective distribution of surplus foods to voluntary and governmental hospitals and steps to obtain adequate payment for hospital care of the indigent.

Frank J. Walter predicted that the cheap labor situation in hospitals was over and that labor-saving devices will have an extensive market in hospitals. He also reviewed the national situation regarding manpower, materials, supplies and surplus commodities.

"The A.H.A. should have a strong forward-looking policy to present to Congress and the public as an alternative to the Wagner-Murray-Dingell Bill," Mr. Walter said. The lack of such a program is our greatest present weakness, he said, but reported that one is now being worked out.

An extensive program on hospital volunteers was a high point of the program.

Dr. L. E. Emanuel, Cottage Hospital, Chickasha, Okla., was inducted as president. Other officers elected were: Francis J. Bath, St. Joseph's Hospital, Omaha, Neb., president-elect; Dr. Frank R. Bradley, Barnes Hospital, St. Louis, first vice president; John R. Stone, Menninger Clinic, Topeka, Kan., second vice president, and Regina Kaplan, Leo N. Levi Memorial Hospital, Hot Springs National Park, Ark., secretary-treasurer.

National Hospital Day Meeting Held in St. Louis

Because of manpower shortages and overcrowding of hospitals, most hospitals apparently skipped the observance of National Hospital Day this year.

St. Louis, however, had an unusual idea and held an all day conference as a special program. The conference opened with a breakfast and papers on postwar hospital planning, U. S. Cadet Nurses and voluntary *v.* compulsory hospital service followed. Following a complimentary luncheon the afternoon was devoted to Blue Cross plans.

An exhibit of stamps depicting nurses, hospitals, doctors and medical scientists, lent by four physicians, was held in Gimbels department store, New York City, from May 8 to 15 as a National Hospital Day event.

Proclamations were issued by President Roosevelt, various governors and mayors, as well as A.H.A. officials.

Let Down Bars for Negroes

More qualified Negroes should be accepted as students in medical colleges and as interns and staff members in New York City hospitals in the opinion of the Medical Society of the County of New York, according to a resolution adopted on April 24. The society opposes racial or religious barriers to membership in medical and surgical organizations. Dr. Peter Marshall Murray stated that the A.C.S. has not been accepting applications for membership from Negroes.

Report Success With Eye and Vein Banks

Two new "banks" were announced during May. The New York Hospital established its eye bank to receive eyes that have been donated by will or from those whose sight is gone because of some defect of the optic nerve. Eye banks, like blood banks, originated in Russia. Professor Valdimir Filatov created the first eye bank and modified the operation whereby sight is restored. He is reported to have 1000 successful transplantations to his credit.

Vein banks are the other new development. These are especially valuable in war surgery in the repair of severed arteries. The first report on the use of vein grafts to reduce the need of amputation was disclosed by three New York surgeons of Columbia-Presbyterian Medical Center: Dr. Arthur H. Blakemore, Dr. Jere W. Lord and Dr. Paul L. Stefko.

Two tubes made of vitallium, six millimeters in diameter and one centimeter long, are used. A segment of vein is inserted into the tubes which are placed at opposite ends of the vein to provide an uncovered stretch in the center. The vein segment is cut long enough to provide cuffs over the tubes. This then can be inserted into a severed artery to form a bridge. The artery is tied over each end of the vein-lined tube. Veins must be preserved by quick-freezing.

Guy Spring Heads Indiana's Statewide Blue Cross Plan

Preliminary steps for forming a statewide Blue Cross plan in Indiana have been approved by the state attorney general, according to an announcement by Sister Mary Reginald at the annual meeting of the Indiana Hospital Association held in Chicago on May 11. Guy W. Spring of the Cincinnati Blue Cross plan has been employed as director of the Indiana statewide plan and an office has been rented in Indianapolis. A board of 21 members is to be elected.

In discussing the plan a motion was presented by E. T. Franklin of the Methodist Hospital, Fort Wayne, recommending that the majority of the directors be associated with participating hospitals, that the contracts be as inclusive as possible and that reciprocity of contracts and benefits be generous. The motion passed without discussion from the floor, although actual decision has been left in the hands of the directors of the plan.

Illinois Association at Work on Statewide Blue Cross Plan

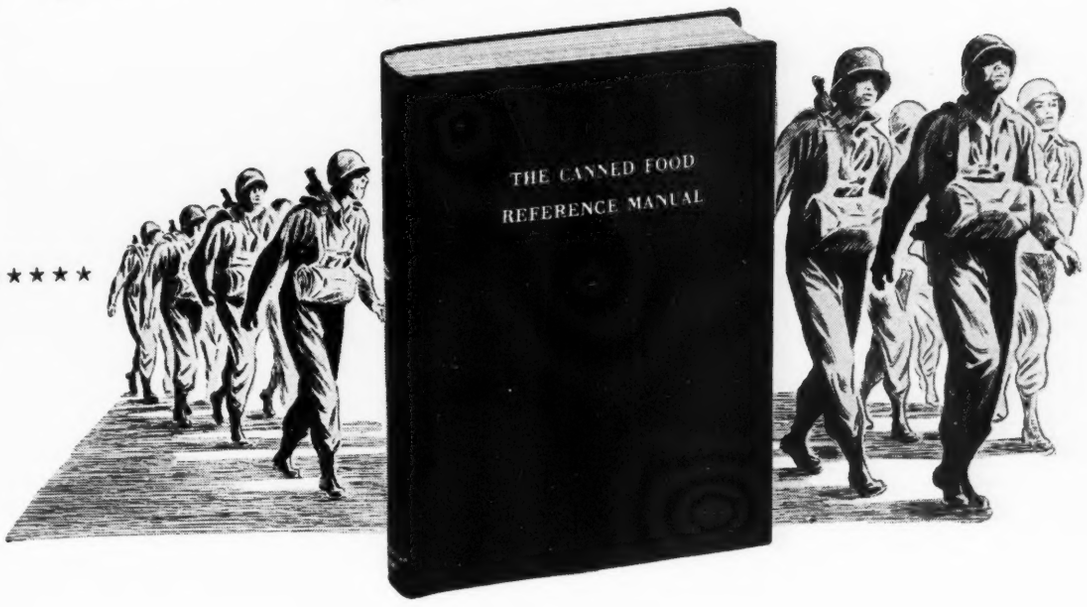
A committee of nine representing the various areas of the state has been appointed by the Illinois Hospital Association to work out a statewide Blue Cross plan in cooperation with the six plans now in the state. Dr. Herman Smith of Chicago is chairman.

The association at its annual meeting on May 11 in Chicago changed its by-laws to make them conform with the A.H.A. by-laws and increased the board of trustees of the state association from seven to eleven members. The secretary-treasurer was made an appointive office.

Butter Program Not Extended

No extension of the War Food Administration's "butter-for hospitals" program, which expired April 30, is being contemplated because almost all hospitals are now able to obtain an adequate supply of butter through normal trade channels, W.F.A. officials stated recently. During the six months' period that the program was in force the 5,000,000 pounds of butter from the set-aside stocks were used or contracted for use. The federal agency has notified firms holding set-aside butter that hospital butter release certificates may not be redeemed with set-aside butter produced after April 1 to fulfill obligations incurred after that date.

Army and Navy Doctors—
Here's a useful book on Fighting Food



HERE'S A BOOK full of condensed information on *nutrition, dietary inadequacies, vitamin* and *caloric values* of *various foods.*

There are also tables on the mineral, iodine, and sulphur contents of canned foods; conversion tables of weights and measures; tables of various amounts of food required to supply energy for different activities; and lots of other compact statistical information about food values.

You may already be familiar with the first edition of "The Canned Food Reference Manual," as it has been distributed to colleges, libraries, and the medical profession generally.

New Edition

This is a brand-new edition, however, to which has been added a host of valuable material. The original purpose of the manual was *not* to serve as an aid to military nutrition, but to provide useful knowledge on canned foods for the whole medical profession. However, since a large part of the fighting man's sustenance must necessarily come from cans, *this book is especially valuable now, to those whose job concerns the nutritional background of the diet and health of our Armed Forces.*

Easy to Carry

The average medical book is a heavy, unwieldy volume. "The Canned Food Reference Manual" measures only 5½" x 8" x 1", small enough for practical use in places where space and weight are at a premium. It's free. Fill out the coupon below and mail.

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Recommends Adding 1810 Beds to Hospitals in Honolulu

Additions to existing hospitals totaling 1810 beds are recommended in a survey of Honolulu hospitals conducted by Capt. Lucius W. Johnson, Medical Corps, U. S. Navy, and member of the editorial board of The MODERN HOSPITAL.

Captain Johnson's recommendation is based on an estimated population of 260,000 after the war. "An additional need which the local hospitals must serve lies in the large number of former service men who will be found in the community after the war ends. More than 10,000 men and women, now in the armed services, have become accustomed to receive high-grade medical and hospital care while on duty. They will not be satisfied with a lower standard of service when they return to civilian life. The government's new plan for vocational rehabilitation of disabled veterans has been announced and it contemplates the use of local hospital beds on a very large scale."

Captain Johnson found extensive overcrowding in Honolulu's hospitals, with "100 per cent occupancy for a considerable period and even added beds, thus increasing the fire hazard and danger of the development of cross-infections."

He recommends that the new beds be distributed as follows: general medical and surgical, 425 beds; obstetric, 48; children, 52; tuberculous, 500; mental disease, 425; feeble-minded, 400, and chronic indigent, 160.

Income Tax Law Benefits Donors to Charitable Groups

The new federal income tax law provides automatic deductions for charitable contributions and other purposes for those persons whose total income is under $5000. Thus, a person subject to this provision can obtain the benefit of the deduction even though he has actually made no contribution.

The 15 per cent limitation on deductions for charitable contributions will still apply to individuals with larger incomes but will be based on adjusted gross income instead of net income as under the existing law. This should bring an increase in contributions from the larger givers.

Congressmen felt that it would be impractical to simplify the income tax returns of those with less than $5000 of income and still keep the credit for actual contributions.

Hospital to Raise $150,000

A $150,000 fund is to be raised by the Memorial Hospital for the Treatment of Cancer and Allied Diseases of New York City in observance of its sixtieth anniversary. The fund will be called the Ewing Memorial Fund in tribute to the late Dr. James Ewing, who was associated with the hospital for thirty years as president of the medical board and director. Income from the fund will be used to support undergraduate and graduate instruction for medical students at Cornell University Medical School and at the hospital, to provide at least two annual lectures on neoplastic diseases and to support special research.

Number of Physicians Increases

A total of 5952 physicians was added to the American Medical Association and 3382 died during 1943, according to data published by the A.M.A. in the *Journal* for May 13. Also, many physicians who received their degrees in December 1943 were not licensed until January 1944 and so are not included in these statistics.

Excluding the physicians in military service, in full-time hospital work, retired, not in practice or engaged in full-time teaching, there remain about 100,000 physicians in private practice in the United States, some of whom are part-time teachers, the *Journal* estimates.

Advancing Knowledge

of nutrition confirms over and over again what important role the RIGHT KIND of proteins play in the process of living.* The proteins of meat are of the right kind, of highest biologic efficacy, adequate for every protein need in the organism.

*"The relative importance of the protein fractions is only now becoming sufficiently known and understood. The proteins guard the body's ability to replace its losses through ordinary wear and tear as well as through disease and operative procedures, and they increase the readiness of wounds to heal. The proteins protect us against infection by increasing the antibody protection of the body. By virtue of their lipotropic power, they help to restrain any tendency to store abnormal amounts of fat in the various organs, notably in the liver. They furnish the factors which control hemorrhage. And an abundant, rich protein supply gives a sense of well-being and vigor and does away with fatigue." (Wilensky, A. O.: The Food Problem in the Present and in the Postwar World. Editorial. Rev. Gastroenterol. 10:314, December 1943).

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO... MEMBERS THROUGHOUT THE UNITED STATES

Kellogg Foundation Asked to Study Missouri Problems

The Missouri Hospital Association, the Missouri State Medical Association, the St. Louis Blue Cross plan and several allied agencies have joined in inviting the Kellogg Foundation of Battle Creek, Mich., to make an extensive survey of immediate and future health needs of the state.

Rural health needs and facilities are of paramount concern to these allied health organizations. The withdrawal of physicians from rural areas into the armed forces and otherwise has made the situation more acute and has resulted in the closing of some private clinics and hospitals.

The need for a coordinated program for the provision of diagnostic centers, community hospitals and the relocation of physicians to rural areas was emphasized at a recent meeting sponsored by the Farm Foundation.

The St. Louis Blue Cross plan has made an intensive effort during the past year to enroll rural residents. It now protects more than 100,000 farmers and residents of small communities.

The Kellogg Foundation has not announced as yet just what response will be made to the request but it has long indicated a deep interest in the problems of better health services for rural areas.

New York Blue Cross Plan Announces Ward Service

A new ward service plan was announced during May by the Associated Hospital Service of New York. For charges of 14 cents for a single individual or 33 cents for a family per week, the subscriber is entitled to practically all of the benefits of the semiprivate plan except that the accommodations are in wards. A large number of New York hospitals are participating.

Individual hospitals will decide whether patients are eligible for ward service. If not, the patient will pay the difference between contract benefits and semiprivate charges.

Associated Hospital Service will encourage employers to pay all or part of the cost of the ward service plan for their employes, Louis H. Pink, president, announced. Roosevelt Hospital, besides agreeing to participate in the plan, has applied for ward service contracts for 373 members of its own maintenance staff, becoming the first employer to apply for the new plan. The hospital will pay the entire cost.

Nurse Recruiting Booklet Being Widely Distributed

WASHINGTON, D. C.—Thousands of copies of a new booklet entitled "Professional Nurses Are Needed" have been distributed jointly by the U. S. Office of Education and the U.S.P.H.S. Division of Nurse Education. Copies have been sent to nursing, public health, hospital and medical organizations, science writers, high school principals and other educational leaders, guidance supervisors, libraries and other groups that might be influential in persuading high school girls to enter nursing.

The pamphlet indicates the need for nurses, the opportunities open and gives much information about nursing schools and how to select students who would be successful in nursing.

Provident Opens Fund Drive

At the first report meeting of its campaign workers Provident Hospital, Chicago, reported that $20,000 in cash has been raised in its drive to raise $200,000 to help ensure the future of the hospital. Hospital authorities are seeking to raise $50,000 of this sum from the south side residents alone and another $100,000 from the city at large. When the $150,000 has been raised, the Julius Rosenwald Fund will present the hospital with the remaining $50,000.

Doctor Questions Prepayment Plans at Iowa Meeting

A note of skepticism regarding the necessity for medical prepayment plans was introduced at the meeting of the Iowa Hospital Association, April 25 and 26, by Dr. Stuart C. Cullen, assistant professor, department of surgery, University of Iowa Medical School. Doctor Cullen questioned whether there was "proof that lack of prepayment plans is a detriment to public health" and whether there really are an overwhelming interest in and a demand for prepayment plans.

Other speakers on the program included Florence King, administrator, Jewish Hospital, St. Louis; L. A. Bradley, manager of the laundry at the University of Iowa Hospitals, and L. C. Zopf, professor of pharmacy, University of Iowa.

New officers elected at the meeting are the following: president, Harold K. Wright, Methodist Hospital, Sioux City; first vice president, Sister Mary Mercy, Mercy Hospital, Cedar Rapids, and second vice president, Louise M. Cordts, Boone Hospital, Boone. Lilyan Zindell, Atlantic Hospital, Atlantic, was reelected treasurer and Verne A. Pangborn, assistant administrator, University of Iowa Hospitals, was reelected secretary.

Foundation Will Underwrite La Guardia's Health Project

The New York Foundation has agreed to underwrite $150,000 of the $250,000 required to start Mayor La Guardia's plan for health and medical insurance. This plan is described in an article by Louis H. Pink in this issue of The Modern Hospital (page 69).

Preliminary studies have been financed by this foundation and also by the Josiah Macy Jr. Foundation.

Mayor La Guardia announced on May 15 that incorporation papers for the nonprofit organization that is to operate the plan would be filed within a week or two when the names of the directors will be made public.

The mayor congratulated the Medical Society of the State of New York for its recent action in approving the United Medical Services, Inc., which will provide prepaid medical insurance for the lower income groups in 17 counties in and around New York City. Noting that the plan covered only major operations and catastrophic illness and was limited to those with incomes under $2500, the mayor still called it a step in the right direction.

Conference on Practical Nurses

Practical nurses will be an indispensable part of postwar nursing. Hilda M. Torrop, president, National Association of Practical Nurse Education, speaking before a meeting of that group May 12 in New York City, stated that her views on this subject are being shared by hospital and public health officials. There is great need for a definition of the practical nurse and her relationship with the registered graduate nurse, to avoid overlapping. Other problems to be faced are working for licensing of practical nurses, agreeing on a standard term for such a worker and recruiting the best candidates. On the same occasion Dr. Frederick MacCurdy, New York State commissioner of mental hygiene, predicted a wider use of practical nurses in state institutions for the mentally ill.

Washington Elects Officers

New officers elected at the annual convention of the Washington State Hospital Association held at Everett General Hospital, Everett, on April 19 were as follows: president, Howard C. Ries, Everett; president-elect, Supt. A. L. Howarth, Deaconess Hospital, Wenatchee; vice president, Supt. W. H. Heath, Tacoma General Hospital, Tacoma, and secretary-treasurer, Supt. John Dare, Virginia Mason Hospital, Seattle.

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To a majority of U. S. hospitals, the problem of preventing corrosion of surgical instruments during sterilization — of maintaining micro-sharp cutting edges — is easily solved. These hospitals take meticulous care with their sterilization techniques. *They use U. S. I. Pure Alcohol.*

For U. S. I. Pure Alcohol has a long, enviable record for "keeping an edge" both in freedom from physiologically harmful ingredients, and in freedom from acidity and other metal-corroding impurities.

In these days when your hard-to-replace instruments are working overtime, getting even more frequent exposure to alcohol, this extra margin of safety can be a conservation measure of real importance. And when you consider the extra margin of safety which U. S. I. Pure Alcohol affords in other hosptial uses, you have a two-fold reason for standardizing on this high-purity product.

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Minnesota Group Defers Adoption of New By-Laws

Proposed new by-laws of the Minnesota Hospital Association were presented at the twenty-first annual convention in St. Paul on May 14 to 16 but adoption was postponed until agreement could be reached as to the proper position of Blue Cross plans in the organization.

Rev. L. B. Benson, retiring president, recommended that legislation be introduced to provide for proper payment for the hospital care of the indigent so that hospitals could offer proper rates of pay to employes.

The yearly licensing of all subsidiary workers, orderlies and nurse aides was recommended by Katherine Densford, head of the University of Minnesota school of nursing.

One of the most important things we can do is to keep a patient from developing a "sick attitude" toward life, declared Dr. William A. O'Brien in urging psychology and sociology as essential elements in occupational therapy in hospitals. Doctor O'Brien also announced the resumption of hospital institutes at the University of Minnesota and stated that the recent institute for fellows of the A.C.H.A. had been an outstanding success.

We can accomplish twice as much in half the time if a hospital can achieve a real spirit of teamwork, declared Frieda Clausen of Miller Hospital, St. Paul. She told of the interruption to laboratory work resulting from 10 unnecessary phone calls while she was trying to do an important differential blood count.

Dr. Thomas E. Broadie of Ancker Hospital, St. Paul, was installed as president. The president-elect is Dina Bremness, Glenwood Community Hospital, Glenwood; first vice president, Sister Christopher, St. Cloud Hospital, St. Cloud; second vice president, Frances Eckman, Miller Hospital, Duluth; treasurer, Nellie Gorgas, St. Barnabas Hospital, Minneapolis, and directors, George Edblom, Winona General Hospital, Winona, and John Mitchell, Colonial Hospital, Rochester.

Missouri Adopts Medical Plan

The Missouri State Medical Association unanimously adopted a plan of prepayment for medical and surgical care for hospitalized illnesses on April 24 and 25. Dr. Carl F. Vohs of St. Louis, chairman of the committee that formulated the plan, was appointed to head a new committee to set it in operation within sixty to ninety days. The Blue Cross plans of St. Louis and Kansas City will handle enrollment. The plan is an indemnity plan and will cost about $2.25 per month for family coverage.

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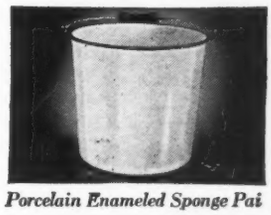
Remember: "Sing a song of sixpence" . . .
About the blackbirds baked in a pie?
Smart folks, then, did everything
To please their King.

• To satisfy both the doctors and their patients, successful hospital management checks regularly the *appearance and performance* of clinical and kitchen ware . . . and re-equips with Vollrath Stainless Steel and Porcelain Enameled Ware—recognized by professional people and patients, alike—for its inherent *beauty, utility* and *durability, famous since 1874.*



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Labor Dispute in New York Hospitals Still Unsettled

Further developments in the labor dispute involving four member hospitals of the Greater New York Hospital Association were revealed at a meeting of the association on April 28.

From the War Labor Board panel have come certain recommendations as to wages, hours and working conditions. These include a 15 per cent increase over present salaries and wages for almost all classes of employes with 20 per cent to some. The panel recommends that the split shift be abolished and a forty-eight hour week be instituted with time and a half for overtime.

In the opinion of Roderic Wellman, counsel for the association, the hospitals will maintain the point that they have taken up to now, that W.L.B. holds no jurisdiction over the voluntary hospital in such a dispute. Accordingly, as a matter of form the hospitals will doubtless write a letter to the W.L.B. disclaiming acquiescence in the panel's recommendations.

Following thorough investigations with the Red Cross and other sources, it was reported by Bernard McDermott, superintendent of Long Island College Hospital, that the government is not intending to use voluntary hospitals to care for the sick and wounded and that it will assume responsibility for those requiring such service in government operated institutions.

Rotary Clubs to Get Kits of Nurse Recruit Material

All of the 3369 Rotary clubs in the United States will soon be provided with a kit of nurse recruitment materials and suggestions by the U.S.P.H.S. and the National Nursing Council for War Service. The idea for such a kit was originally developed by the Civilian War Service Committee, which has been active in promoting nurse recruitment in Illinois.

A demonstration of Rotary participation in nurse recruitment was held in Chicago on May 16 for Rotarians in the 35 clubs of northern Illinois. Each member of a Rotary club is being asked to be a committee of one to interest at least three girls in entering nursing. Rotary clubs are being urged to cooperate with the local nursing councils in their recruitment campaigns.

Private Duty Fees Standardized

The Greater New York Hospital Association and two local nursing organizations have approved standardized fees for registered professional private duty nurses in New York City and Long Island. Effective May 1, the rates are $7 for eight hours plus charge for the nurse's meals, $10 for twelve hours plus charge for the nurse's meals and $12 for a resident nurse (formerly termed 24 hour duty).

Coming Meetings

June 1-2—National Executive Housekeepers' Association, Bellevue-Stratford Hotel, Philadelphia.

June 6-8—American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Hotels Statler, LaFayette and Buffalo, N. Y.

June 12-16—American Medical Association, Palmer House and Stevens Hotel, Chicago.

June 20-22—Maritime Hospital Association, Admiral Beatty Hotel, St. John, N. B.

June 26-30—Canadian Nurses' Association, Winnipeg, Man.

Aug. 25-26—Institutional Laundrymen's Association, Bellevue-Stratford Hotel, Philadelphia.

Sept. 6-9—American Congress of Physical Therapy, Hotel Statler, Cleveland.

Oct. 2-6—American Hospital Association, Hotels Statler and Cleveland, Cleveland.

Oct. 3-5—American Public Health Association, Hotel Pennsylvania, New York City.

Oct. 23-27—American College of Surgeons Clinical Congress, Stevens Hotel, Chicago.

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

1945

April 11-12—Texas Hospital Association, Galveston.

Trustees Give Sanatorium to Citizens of Tucson

The Desert Sanatorium at Tucson, Ariz., which was acquired in 1929 by the late Alfred W. Erickson, founder of McCann-Erickson Advertising Agency, has been turned over by the trustees of Mr. Erickson's estate to the citizens of Tucson.

The hospital section of the sanatorium was closed down last May owing to the difficulties of operating it as a result of depleted staffs. However, with the erection of a huge aircraft plant in Tucson, the facilities of the city's only hospital were so overtaxed that a committee of citizens approached Mrs. Erickson regarding the possibilities of either renting or buying the sanatorium and its adjoining hospital accommodations.

The trustees offered to deed the 160 acres, its collection of 18 buildings and all hospital equipment to the citizens of Tucson provided sufficient public interest in their maintenance was shown and that a substantial sum of money could be raised to ensure operation of the institution with a modicum of efficiency. The committee raised $250,000 and the board turned over the property to the organization for the sum of $1.

The organization that will operate the sanatorium on a nonprofit basis has renamed it the Tucson Medical Center Corporation. It is expected to enlarge the property to double its present capacity and, as a community hospital, its facilities will be open to all licensed physicians in the state.

House Passes Amended "G. I. Bill of Rights"

WASHINGTON, D. C.—The House of Reresentatives on May 18 passed the amended "G. I. Bill of Rights" defining the benefits that will be available to veterans of the present war. The bill was then sent to a conference with the Senate to iron out differences inserted by House amendments.

Increased hospital services are provided for veterans and new facilities are to be built under priorities second only to those for the War and Navy departments. The House struck out the Senate-approved authorization for an initial $500,000,000 for the program but provided that necessary sums be appropriated as needs arise.

It has been estimated that 73,000 veterans will receive care in hospitals of the Veterans Administration in 1944, 142,000 in 1950 and 300,000 in 1975. Present facilities and those under construction will total 100,000 beds, so substantial additions will be needed.

Labor Conference Urges Life-Time Medical Care

The International Labor Conference, meeting in Philadelphia during May, recommended cradle-to-the-grave medical service through social insurance or through public medical service. The recommendations on this point were adopted by a vote of 55 to 5. The conference represents employers, employes and governments of the world in approximately equal thirds.

"Complete preventive and curative care should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature," the report declared. Free choice of doctors and patients was endorsed.

Celebrates Silver Anniversary

Mount Sinai Hospital, Chicago, will celebrate its twenty-fifth anniversary at a dinner and meeting held at the Standard Club in Chicago on June 4. A special feature of the celebration will be an exhibit of some of the hospital services, including the laboratory, x-ray department and physical therapy department.

Group Organized to Care for Advanced Cancer Patients

The National Foundation for the Care of Advanced Cancer Patients, Inc., was organized on May 4 by Dr. Frank E. Adair and associates to provide beds and care in already established institutions and to finance the establishment of new institutions if necessary for the aid of advanced cancer patients of moderate means. Doctor Adair is president of the American Society for the Control of Cancer and chairman of the cancer committee of the A.C.S. The fund is to be nonsectarian.

A fund of $500,000 will be sought from private donations. Julius Jay Perlmutter, a merchandise broker, was chairman of the organizing committee. "Indigent cancer patients are comparatively well provided for today," he said. "Suitable places are needed particularly for the advanced cancer patients of moderate means. Our ultimate aim is to provide low-cost private room and bath for every such patient, to be referred to the foundation with as little red tape as possible by cancer physicians. Many cancer patients in the terminal stage die in their own homes with practically no medical or nursing care."

He quoted estimates of the state department of health of Massachusetts that there should be one hospital bed available for cancer patients for every 10 deaths.

Laboratory Building Given to Mount Sinai Hospital

A fund to be used for the construction of a modern research laboratory building was presented to Mount Sinai Hospital, New York City, by Dr. A. A. Berg in honor of his brother, the late Dr. Henry W. Berg. Construction of the laboratory building will be started as soon after the war as material and labor become available. A site centrally located in the hospital's existing group of 18 buildings has been chosen.

The building is planned to provide accommodations for research in bacteriology, pathology, physiology, chemistry, gastro-enterology, cardiology, hematology, endocrinology, metabolism, allergy and biophysics. The hospital's electron microscope, ultra-centrifuge and other specialized research apparatus will be housed in the new structure.

"Through Doctor Berg's gift," hospital trustees asserted, "Mount Sinai Hospital will maintain its position in the forefront of scientific research and will be enabled to make a real contribution toward making New York City a world center of medicine."

Paralysis Foundation Makes Study Grant to Stanford

To increase the amount of training available for physical therapy technicians, the National Foundation for Infantile Paralysis has made a two year grant totaling $34,080 to the Stanford University School of Health (Women), it was announced on April 20 by Basil O'Connor, president of the foundation.

The grant, which is in addition to other funds given by the foundation to this university, is to strengthen the physical therapy technicians' school and to prepare syllabi and text materials.

"The 1943 epidemic of infantile paralysis emphasized the serious lack of physical therapy technicians and qualified teachers," Mr. O'Connor stated.

All Health Functions to U.S.P.H.S.?

Congressman A. L. Miller of Nebraska has introduced in Congress a bill to transfer to the U.S.P.H.S. those functions of the Secretary of Labor and the Children's Bureau that are concerned with health, including industrial hygiene. As a former state health director in Nebraska, Doctor Miller states that the two agencies and their personnel are jealous of each other, resulting in confusion of plans and conflict of ideas.

Health Leaders Address Carolinas-Virginias Session

Subjects with broad implication to the hospital field occupied the attention of those attending the fourteenth annual Carolinas-Virginias Hospital Conference, May 17-18, in Asheville, N. C. These were presented by national figures in the hospital, public health, educational and social welfare fields indicating trends that will influence the postwar period. Every session was thought-provoking and the program as a whole set new standards for regional gatherings.

Hospital people in these four southern states received from Dr. Jack Masur first-hand information on the rehabilitation program of the Office of Vocational Rehabilitation in Washington and the part they will be expected to play in it. Complete details of the workings of the Emergency Infant and Maternal Care program as conducted by the Children's Bureau also were provided.

The shadow of government participation in hospital care insurance threatens the voluntary pattern, according to Dr. R. H. Bishop Jr., president, American College of Hospital Administrators. Consequently, hospitals must lend every effort to the accelerated program for enrollments in the Blue Cross. Organized labor is pressing for a socialized health program and Blue Cross plans are handicapped by being unable to offer medical coverage with hospital coverage. Doctor Bishop emphasized the need for the A.H.A. to establish a commission under able leadership that would further the cause of voluntary group insurance among hospitals and trustees.

Hospitals can make a real contribution to community public health projects, according to Dr. J. Henry Highsmith, director, division of instructional service, North Carolina Department of Public Instruction. Doctor Highsmith pointed out how hospitals can help the high schools in health teaching through extending the use of their facilities and by so doing reap the benefit of volunteer labor and promote interest among high school girls in becoming nurses. North Carolina is embarking upon a state program of public health teaching in high schools similar to that inaugurated by Michigan.

Now is a good time to cut the pattern for a postwar personnel program Robert S. Hudgens, superintendent, Emory University Hospital, Emory University, Ga., asserted. No hospital, no matter how small, can ignore the issue. Someone must be placed in charge. He warned against too great optimism regarding a decline in labor costs immediately following the war. Many hospitals are already dealing with labor unions and others will have to, he believes. A good personnel program will help materially in meeting this situation.

Any surplus that hospitals may be accumulating should be set aside for future contingencies. It will serve as a cushion in the postwar period. Such caution was urged by J. L. Melvin, superintendent, Park View Hospital, Rocky Mount, N. C. He also advised giving as much thought to charges as to collections.

The following officers were elected by the four associations:

North Carolina: T. J. Alford, Roanoke Rapids Hospital, president; Dr. H. L. Brockman, High Point, president-elect; Sample B. Forbus, Watts Hospital, Durham, secretary-treasurer; Dr. J. B. Whittington, City Hospital, Winston-Salem, retiring president of the State Association, and E. T. McKeithan, Moore County Hospital, Pinehurst, trustees.

South Carolina: Dr. V. P. Patterson, Pryor Hospital, Chester, president; George W. Holman, York County Hospital, Rock Hill, president-elect; M. L. Moser of Columbia, treasurer, and Rev. W. M. Whiteside, South Carolina Baptist Hospital, Columbia, and Katherine O. Altman, Marion Sims Memorial Hospital, Lancaster, trustees.

Virginia: Ferma Hoover, Memorial Hospital, Danville, president; Robert G. Whitton, Alexandria Hospital, Alexandria, vice president; M. Haskins Coleman Jr., Richmond, secretary; Kenneth L. Williams, Mattie Williams Hospital, Richlands, treasurer, and Charles Dabbs, Arlington Hospital, Arlington, Annie Jo Blanton, Martha Jefferson Hospital Sanitarium, Char-

Government restrictions eased on heavy duty equipment for mass feeding

● In line with its recognition of the importance of efficiency in mass feeding, the government has considerably relaxed restrictions on heavy duty cooking equipment. Accordingly it is now possible for cafeterias, restaurants, hospitals, schools, hotels and other institutions engaged in mass feeding, to obtain equipment if it is needed.

Adequate facilities for proper food preparation are essential to the maintenance of approved standards of nutrition. These standards must be maintained in order to protect the health and energy of war workers. And in this total war, every loyal citizen *is* a war worker.

For information on Magic Chef Heavy Duty Gas Ranges consult your equipment supplier or just drop us a line.

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lottesville, and Sara Hamilton, Winchester Memorial Hospital, Winchester, trustees.

West Virginia: Dr. A. F. Lawson, General Hospital, Weston, president; E. A. Groves, Kanawha Valley Hospital, Charleston, president-elect; B. B. Dickson, Stevens Clinic Hospital, Welch, vice president, and Charles E. Vadakin, Fairmont General Hospital, Fairmont, secretary-treasurer.

OFFICIAL ORDERS

April 15 to May 15

Construction.—Order L-41 was amended April 19 and now provides that no permission is required for construction of less than $1000 for a hospital unless a public utility connection requires W.P.B. approval. W.P.B. warned on April 25 that the new order was not a drastic relaxation of previous control. There is some relaxation on certain items.

Electric Flat Irons.—Authorization to produce approximately 200,000 irons has been granted by W.P.B., according to an announcement of May 1. The year's program calls for 2,000,000.

Fluorescent Lighting Fixtures.—More metal in fluorescent lighting fixtures has been permitted since April 21.

Ice Creams and Mix.—W.F.A. on May 2 permitted manufacturers of frozen dairy products to make more and richer ice cream than at any time since February 1943. For May and June manufacturers are permitted to use 75 per cent of the milk solids that they used in the base period (instead of 65 per cent as heretofore) and can raise the maximum milk solids content to 24 per cent instead of 22 per cent. However, products sold to the Veterans Administration are exempt from the limitations but no such exemption was made for voluntary hospitals.

Laboratory Reagents.—Manufacturers of these solutions containing U. S. tax-paid ethyl alcohol may add to their ceiling prices the exact amount of the tax in excess of $4 a proof gallon for the alcohol contained in the solution, the O.P.A. announced April 18.

Medical and Surgical Furniture and Related Equipment.—Restrictions on the use of zinc, alloy steel and aluminum in the manufacture of these items were deleted from Schedule 3 or Order L-214 on May 5, W.P.B. announced.

Paper Cups.—Direction 2, as amended May 1, to PR 3 gives hospitals the privilege of using their M.R.O. ratings to obtain paper cups and paper food containers for serving their patients, as well as for their employes.

Quinidine.—Further restrictions on this product were announced on May 9 by W.P.B. A physician's prescription is now required of the ultimate consumer and can be honored only if it certifies that it is for cardiac disorder. Quantities are limited to 50 three grain tablets or capsules or equivalent.

Rationing.—New hospitals may obtain a reserve allotment of rationed foods equal to fifteen days' supply if they began operating after January 1. Institutional users' allotments of points were reduced by 50 per cent on May 3 to take account of the reduction in point values of meats.

Rationed Foods for Research.—O.P.A. through a new provision effective April 29 has made it easier for those needing rationed foods for research purposes to obtain them. All these engaged in food and nutrition research (whether they were so engaged in 1942, the base year, or have become so engaged since that time) may apply to their O.P.A. district office for allotments and get them provided it is found "in the public interest" to do so. The real value of butter as a source of Vitamin A, what effect, if any, special diets may have in the regeneration of blood in blood donors are among typical problems being studied.

Refrigerant Gas.—Sharp restrictions on deliveries of F-22 for use in any system of comfort air conditioning or for storing and dispensing carbonated or malt beverages were ordered by W.P.B. on April 21.

Shellac.—Revocation of Order M-106 must not be interpreted as indicating that sufficient shellac will be available to meet all civilian requirements, warned W.P.B. on April 21. Limitations on the use of alcohol will make it impossible to produce appreciable quantities of floor and furniture varnishes made from shellac.

Typewriter Rationing. — New typewriters in the hands of dealers and used typewriters were freed from O.P.A. rationing and W.P.B. restrictions April 22. Distribution of new typewriters in the hands of manufacturers is not affected by this action; sales and delivery of such machines are still controlled by W.P.B.

ABOUT PEOPLE

(Continued From Page 82)

Marian G. Randall, who has served for the past several years in the war-time position of principal nursing consultant in the U. S. Public Health Service assigned to the Office of Civilian Defense medical division, has been appointed director of the Henry Street Visiting Nurse Service, New York City, effective June 1. Miss Randall is chairman of the committee on administration, National Organization for Public Health Nursing.

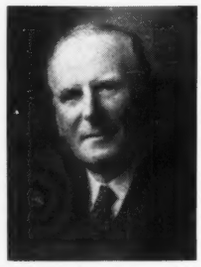
Helen G. Schwarz, former dean of the College of Nursing and Health, University of Cincinnati, and director of nursing service, Cincinnati General Hospital, has been appointed assistant director in charge of the eastern area, division of nurse education, U. S. Public Health Service, F.S.A.

Lois Stice, formerly editorial assistant on the staff of the medical division, Office of Civilian Defense, is now a member of the staff of the informational service, National Research Council, of which **Maj. Gen. James C. Magee,** retired, former surgeon general of the Army, is executive officer.

Dr. Wilbur Sawyer, director of the International Health Division, Rockefeller Foundation, was appointed director of the health division, United Nations Relief and Rehabilitation Administration, on June 1.

Alfred H. Marshall, city editor of the *New Haven Register,* has accepted the position of public relations director of New Haven Hospital, New Haven, Conn.

Capt. Anna Louise Barry, principal chief nurse at Deshon General Hospital, Butler, Pa., was retired by the War Department in May after serving for twenty-five years in the Army Nurse Corps in both the United States and the Philippines. Announcement was also made by the War Department of the retirement of **Capt. Helena Clearwater,** principal chief nurse at Rhoads General Hospital, Utica, N. Y. Captain Clearwater was at Pearl Harbor on Dec. 7, 1941. She was awarded the Legion of Merit and was cited by Lt. Gen. Delos C. Emmons.



Sidney Lamb, general secretary of the Merseyside Hospitals Council, Inc., Liverpool, England, has retired after nearly twenty years of service to that organization. Mr. Lamb, for several years a member of the editorial board of The MODERN HOSPITAL, built up the Merseyside organization to one of the most comprehensive contributory schemes in England. It assumes responsibility for the hospital service of approximately 1,000,000 Merseyside workers and their dependents. Mr. Lamb has also been active in the International Hospital Association and served as its general secretary and treasurer.

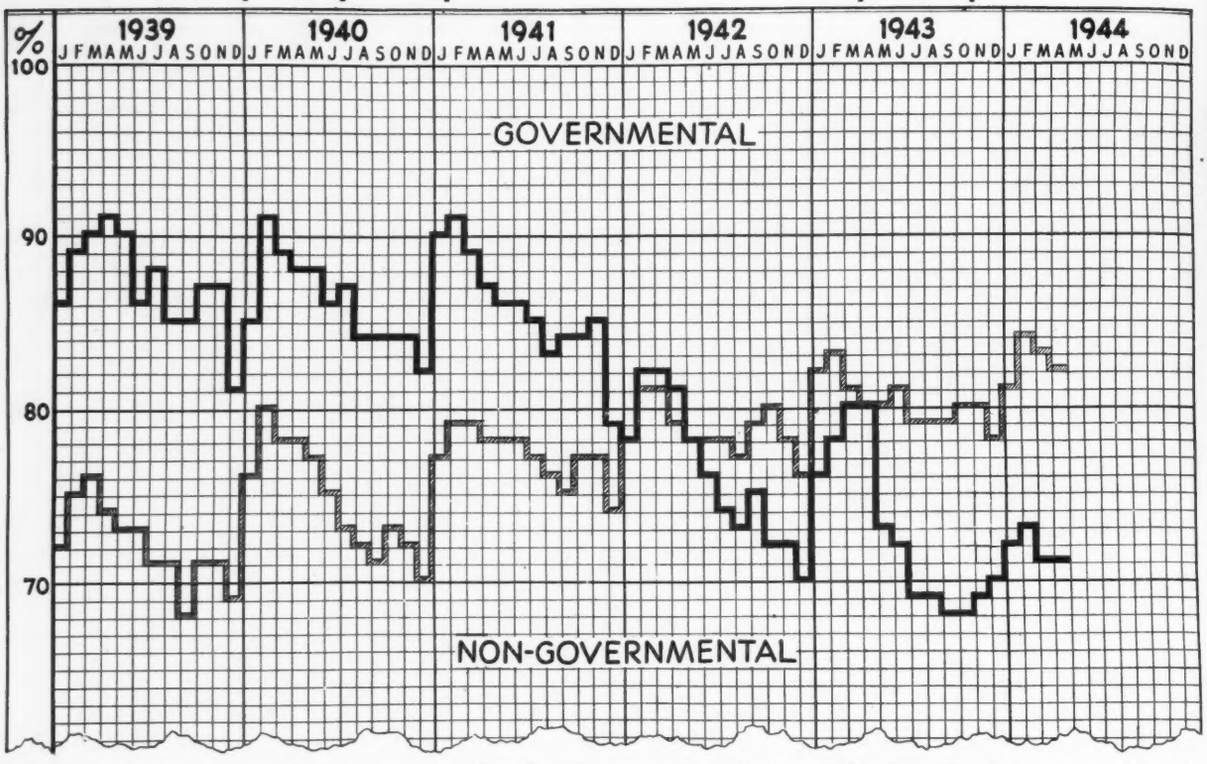
Deaths

Mary B. Dowling, at one time superintendent of nurses at Polyclinic Hospital, New York City, died recently at her home in Utica, N. Y. Prior to her death, Miss Dowling was head nurse at the Blythedale Home at Valhalla, N. Y.

John A. Garvin, chairman of the personnel committee of New Jersey Orthopaedic Hospital, Orange, N. J., died May 12.

Lt. Leo M. Friedman, public relations executive at Montefiore Hospital, New York City, from 1940 until his enlistment in the Army in May 1942, was killed in action on the Anzio beachhead. He was a lieutenant of infantry and was leading a platoon in the forward area at the time.

Occupancy Drops a Point in Voluntary Hospitals



Occupancy in nongovernmental general hospitals dropped one point in April but continued high. It was two points higher than in April 1943. In governmental general hospitals also there was a one point drop in occupancy. It was nine points lower than a year ago.

Fifty-eight new hospital building projects were reported from April 17 to May 15, with 56 giving costs of $8,217,000. This brought the year to date total to $39,701,000. Additions and nurses' homes constituted the bulk of the new construction projects reported during the last fortnight.

HEALTH-BUILDING

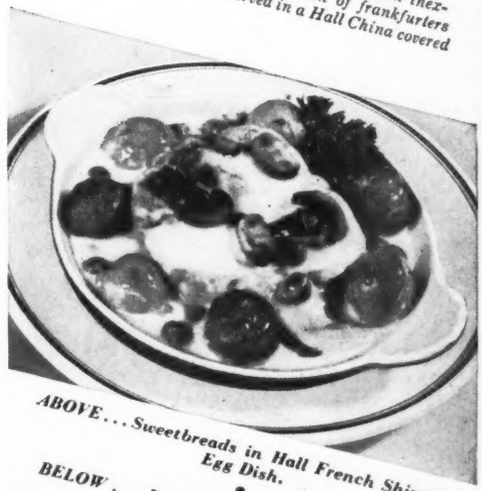
ORIGINAL RECIPES IN FAMOUS HALL FIREPROOF CHINA

★ *LEFT . . . Frank and Johnny Dinner. An inexpensive, yet very delicious combination of frankfurters and vegetables baked and served in a Hall China covered casserole.*

ALL foods lend themselves to casserole cookery—and in delicious, health-building combinations that other cooking methods do not permit.

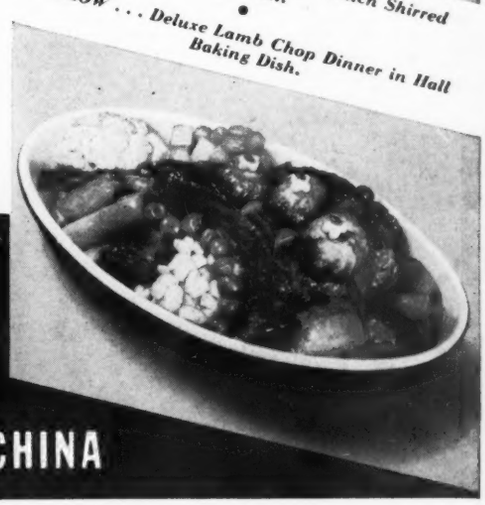
The ware used for casserole cookery is as important as the recipe itself. Genuine Hall China is perfect for the purpose. It is the only known china that is crazeproof, fireproof, stainproof, and absorption-proof because it is made by an exclusive, secret process. Its thick walls, designed for perfect distribution of heat, prevent scorching or partial cooking, and keep food over-hot for protracted serving.

A purchase of Hall China is an investment that pays its way, for the wholesomeness of casserole cookery helps the patient, and the sturdiness of the ware keeps replacement at a minimum.



ABOVE . . . Sweetbreads in Hall French Shirred Egg Dish.

BELOW . . . Deluxe Lamb Chop Dinner in Hall Baking Dish.



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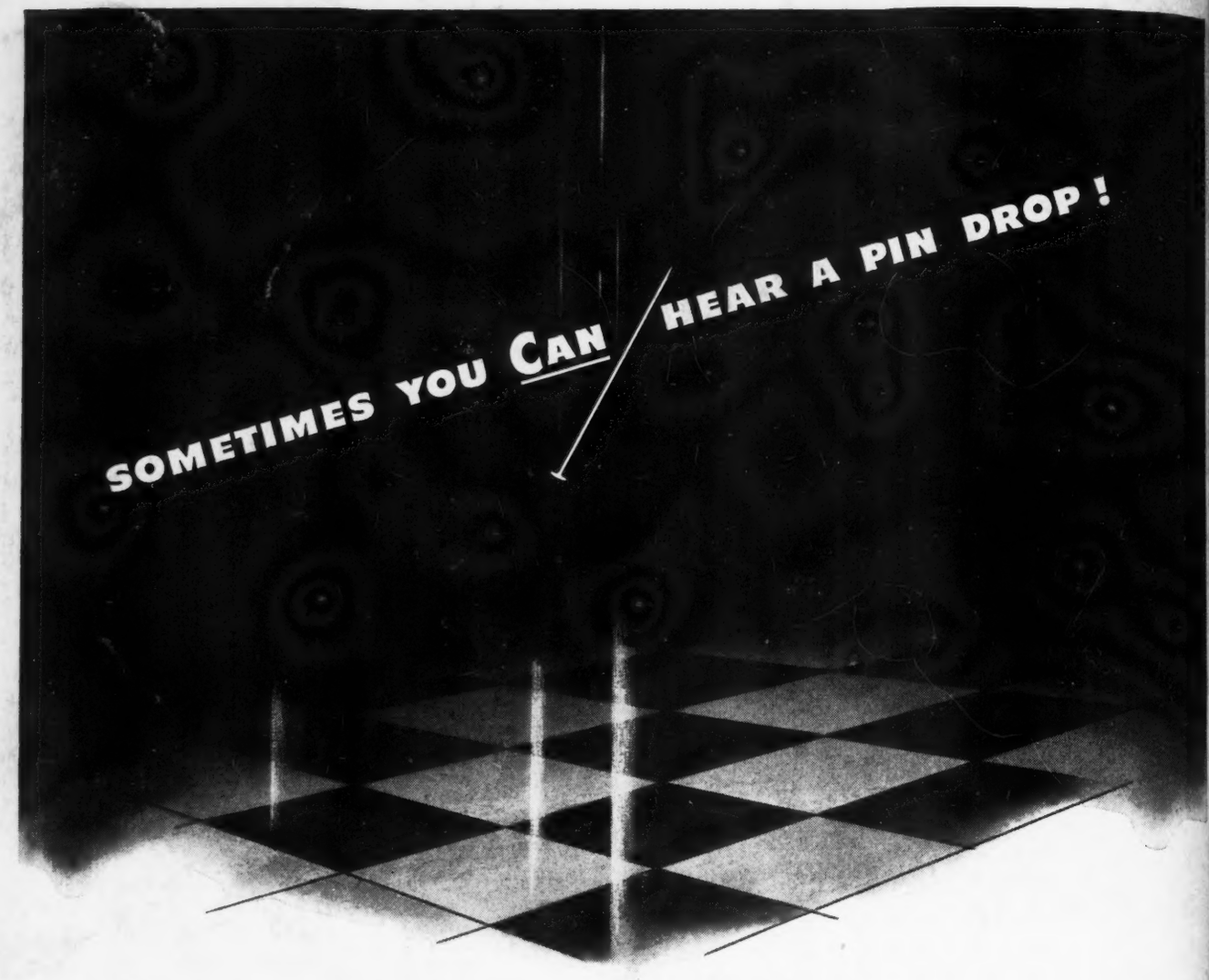

IT'S PROBABLY the littlest noise you ever heard. But to a sick and feverish patient, a hundred and one such little noises are exaggerated into nerve-jabbing clamor.

Today, there's more noise on every floor. Overcrowding is responsible along with inexperienced help. The net result is that recoveries are retarded when they should be hastened . . . overworked staffs are annoyed when they should be calmed.

There's a simple, effective way to convert noise into a gentle hush. Leading hospitals are Sound Conditioning with Acousti-Celotex*. In every case the benefits to both patients and staffs have been amazing. Quiet pays dividends!

Prove it to yourself by quieting one noise source first—a diet kitchen or corridor. Acousti-Celotex*, America's most widely used acoustical material, can be applied quickly and quietly. It can be painted without loss of efficiency.

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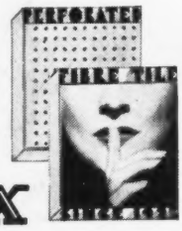

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